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MONTANA FIRST JUDICIAL DISTRICT COURT
LEWIS AND CLARK COUNTY

ROBERT BAXTER, STEVEN STOELB, STEPHEN SPECKART, M.D., C. PAUL LOEHNEN, M.D., LAR AUTIO, M.D., GEORGE RISI, JR., M.D., and COMPASSION & CHOICES, Plaintiffs, v. STATE OF MONTANA and MIKE McGRATH, Defendants.	Cause No. ADV 2007-787 **DEFENDANTS' COMBINED SUMMARY JUDGMENT PRINCIPAL AND RESPONSE BRIEF**

BACKGROUND

Plaintiffs are four doctors and two patients with no relationship to those doctors who claim a constitutional right to physician-assisted suicide free from supervision or review by the patients' treating physicians, their families, medical authorities, or law enforcement. They do not cite or challenge any law that targets them, their intimate personal or medical decisions, or their rights to receive all appropriate medical care to palliate their end of life suffering. Instead,

they seek a partial repeal of Montana's homicide law in an unprecedented effort to immunize from prosecution persons who act with the intent to kill. Although Plaintiffs acknowledge that palliative care--including care that may ultimately hasten death--is available to them, that doctors have an ethical obligation to provide such care, and that provision of such care is not a criminal offense under Montana law, Plaintiffs want more. They insist that death must be a self-determined and physician-assisted ***event***, not simply a pain-free ***process***.

The interest Plaintiffs claim, and the right they assert arises from that interest, is foreign to Montana law. Unlike other groups that have sought refuge under the Constitution's protections, and despite the fact nearly all Montanans will find themselves or a loved one in Plaintiffs' situation at some time in their lives, Plaintiffs have chosen to bypass the political process altogether, to avoid a public debate and the scrutiny of the broader medical community, and to deny the people of Montana their sovereign right to deliberate on and choose their own considered path through this thicket of biomedical policy.

Unless and until Montanans' legislature decides to start down the rarely traveled path toward a regulated regime of physician-assisted suicide, the Court should refuse to blaze a trail. The State has a compelling state interest in drawing a bright line at the point where one person intends to cause another's death. This interest is critical when that person serves in a medical role. For now, the law is the best protection against the worst abuses that can occur when physicians, alone and without any established protocol or procedure, would assist a patient's suicide based on a set of inherently complicated determinations of terminal illness, mental competency, informed consent, and the entirely unsupervised set of death-causing acts that Plaintiffs euphemistically propose as "aid in dying."

End of Life Care in Montana

Montanans who are terminally ill have a variety of options for end of life care. See Aff. of Dr. Thomas V. Caughlan, Ex. 1. One option is palliative care, which is designed to relieve pain and suffering after curative treatment fails. Id. ¶ 8. The physician applies various methods, primarily drug therapy, to promote a peaceful and humane death. Id., ¶ 9. The type

and doses of these drugs can be "staggering," even to those who treat these problems on a regular basis. Id. They include opiates of all kinds – administered intravenously, subcutaneously, transdermally, orally and intrathecally – as needed to control pain; anticholinergic drugs to help dry secretions in people with respiratory problems; antiemetic drugs to help nausea and vomiting; benzodiazepine drugs for anxiety; and major tranquilizers (antipsychotics) for delirium. Id.

In palliative care, the intent of the physician is to relieve pain and suffering, although the unintended consequence of medicating, particularly with opiates, may be to hasten death through respiratory depression. Ex. 1, ¶ 11. Palliative care is nonetheless a universally accepted practice because death occurs on its own terms. This is in contrast to active euthanasia, where the physician resorts to death itself as the means of ending suffering. Id., ¶¶ 11-12.

It is the policy of the State of Montana to ensure the adequate treatment of intractable pain through all medically appropriate means, without fear of legal consequences. See Montana Board of Medical Examiners Statement on the Use of Controlled Substances in the Treatment of Intractable Pain, 3/13/96, attached as Ex. 2. The AMA Code of Medical Ethics imposes a duty on physicians to provide effective palliative treatment, "even if it may foreseeably hasten death." (Pls.' Adm. No. 16, attached as Ex. 3.) Nurses likewise are instructed to "use full and effective doses of pain medication for the proper management of pain in the dying patient," even at the expense of life. American Society for Pain Management Nursing, ASPMN Position Statement on Pain Management at the End of Life, www.aspmm.org/Organization/documents/EndofLifeCare.pdf.

The United States Supreme Court endorsed this practice in Vacco v. Quill, 521 U.S. 793 (1997), suggesting that a patient's constitutional rights would be violated if physicians were prosecuted for administering even risky palliative care. Id., 521 U.S. at 807, n.11; accord Washington, et al. v. Glucksberg, et al., 521 U.S. 702, 736-37 (1997) (O'Connor, concurring) ("The parties and *amici* [including Montana] agree that in these States a patient who is suffering from a terminal illness and who is experiencing great pain has no legal barriers to obtaining

medication, from qualified physicians, to alleviate that suffering, even to the point of causing unconsciousness and hastening death.").

Hospice care is an alternative to palliative care provided in other settings. (Ex. 1, ¶ 8.) It requires a determination by two physicians that the patient has six months or less to live. It also requires the patient's acknowledgment that they are at the end of life, and are willing to forego any further aggressive medical therapy to prolong their lives. Id. Hospice and palliative medicine is considered a specialty that may be certified by the American Board of Medical Specialties. Id., ¶ 9. Both palliative and hospice care are examples of physicians providing "aid in dying." (Id., ¶ 11.)

In addition to end-of-life care, Montana law recognizes the rights of its citizens to consent to withdrawal of life support. The Montana Living Will Act was enacted in 1985, and was renamed the Montana Rights of the Terminally Ill Act in 1991. Mont. Code Ann. Tit. 50, ch. 9, pt. 1. Shortly after the United States Supreme Court's decision in Cruzan v. Director, Missouri Dept. of Health et al., 497 U.S. 251 (1990), the Montana legislature amended the Act to specifically authorize third-party consent to withholding or withdrawal of treatment. Mont. Code Ann. § 50-9-106 (1991).

Homicide and Suicide Under Montana Law

Homicide has always been a crime in Montana. See Mont. Crim. Laws 1879, ch. 4, §§ 18-40. Under the Revised Codes, murder was defined as the unlawful killing of a human being, with malice aforethought. Rev. Codes Mont. 1947 § 94-2501 (1947). Murder was designated by degree, with first degree murder being "all murder which is perpetuated by means of poison, or lying in wait, torture, or by any other kind of willful, deliberate, or premeditated killing." Rev. Codes Mont. 1947 § 94-2503 (1947). All other murder was murder in the second degree. Id.

In 1973, Montana adopted a new criminal code. The first two purposes of the 1973 Criminal Code is "to forbid and prevent conduct that unjustifiably and inexcusably inflicts or threatens harm to individual or public interests" on one hand, and "to safeguard conduct that is

without fault from condemnation as criminal" on the other. Mont. Code Ann. § 45-1-102. Homicide is now divided into three general categories: deliberate, mitigated deliberate; and negligent homicide. The requisite mental states for these offenses are purposely, knowingly, or negligently. Mont. Code Ann. §§ 45-5-102(1); -103(1); -104.

A person acts purposely with respect to a result or conduct described by a statute defining an offense "if it is the person's conscious object to engage in that conduct or to cause that result." Mont. Code Ann. § 45-2-101(66) (2007). Even if it is not the person's "conscious object" to cause a particular result, the person may nonetheless be criminally liable if the result involves the same kind of harm or injury as contemplated but the precise harm or injury was different or occurred in a different way, unless the actual result is too remote or accidental to have a bearing on the offender's liability or on the gravity of the offense. Mont. Code Ann. § 45-2-201(2); see State v. Sherer, 2002 MT 337, ¶ 19, 313 Mont. 299, 60 P.3d 1010. A person acts "knowingly" when the person is "aware of the person's own conduct or that the circumstances exist," or "is aware that it is highly probable that the result will be caused by the conduct." Mont. Code Ann. § 45-2-101(35) (2007).

Deliberate homicide is mitigated where a person acts "under the influence of extreme mental or emotional stress for which there is reasonable explanation or excuse." Mont. Code Ann. § 45-5-103(1). A person acts "negligently" when the person "consciously disregards a risk that the result will occur or that the circumstance exists or when the person disregards a risk of which the person should be aware that the result will occur or that the circumstance exists." Mont. Code Ann. § 45-2-101 (43) (2007).

While suicide is not illegal in Montana, it is a crime for a person to assist or solicit a suicide. Mont. Code Ann. § 45-5-105 (2007). The prohibition against assisting or soliciting suicide has been a part of Montana law since 1895 and was recodified as part of the 1973 Criminal Code. There are no Montana Supreme Court opinions interpreting this statute, and no known prosecutions for assisted suicide. See Aff. of John P. Connor, ¶ 7, attached as Ex. 4. The Annotator's Note explains "[t]he reason for making aiding or soliciting a suicide a separate

offense is that such an act indicates a dangerous disregard for human life." Criminal Law Commission Comments to Mont. Code Ann. § 45-5-105.

Palliative Care, Even If Potentially Lethal, Is Not Homicide In Montana.

In order for a physician to be prosecuted for homicide in Montana, proof of criminal intent is required. State v. Korrell, 213 Mont. 316, 328, 690 P.2d 992, 999 (1984) ("without criminal intent, there can be no moral blameworthiness, crime or punishment."). Criminal intent is lacking in palliative care because the physician's purpose is to relieve suffering--not to end life. Ex. 1 ¶ 11. Even with aggressive administration of medication in palliative care, death is a secondary, unintended consequence and, absent other factors, is not a criminal offense. (Connor Aff. ¶ 8, Ex. 2.)

Montana law does not – indeed, cannot – infringe upon the authority of physicians to provide, or the rights of their patients to receive, "aid in dying" insofar as "aid in dying" involves legitimate, palliative care. Palliative care is not homicide because the principle of "double effect" negates criminal intent:

> [T]here is an ethical distinction between providing palliative care which may have fatal side effects and providing euthanasia. Whereas the goal in palliative care is providing comfort care to relieve suffering even though death may occur, the goal of euthanasia is itself to cause death and through death relieve the suffering. Perhaps a subtle distinction, but an important one, for in providing palliative care the intent is to relieve suffering, not to kill.

Kansas v. Naramore, 965 P.2d 211, 214 (1998), quoting Gordon and Singer Decisions and Care at the End of Life, 346 Lancet 163, 165 (July 15, 1995); see also, Vacco, 521 U.S. at 802-03:

> The law has long used the actors' intent or purpose to distinguish between two acts that may have the same result. ("The . . . common law of homicide often distinguishes . . . between a person who knows that another person will be killed as a result of his conduct and a person who acts with the specific purpose of taking another's life"); . . . ("If A., with an intent to prevent gangrene beginning in his doth without any advice cut off his hand, by which he dies, he is not thereby *felo de se* for tho it was a voluntary act, yet it was not with an intent to kill himself"). Put differently, the law distinguishes actions taken "because of" a given end from action taken "in spite of" their unintended but foreseen consequences.

See also, Ex. 1, ¶ 11.

In Quill, the United States Supreme Court held that state criminal statutes making it a felony to assist a suicide did not violate the equal protection clause of the Fourteenth Amendment. The Court in Quill and the companion case of Washington et al. v. Glucksberg, et al., 521 U.S. 702 (1997) were careful to frame the interest at stake as the "right to commit suicide with another's assistance," so as not to infringe on the obligation of physicians to provide palliative care, despite the risk that those drugs themselves will kill. Id., 521 U.S. at 724, 736-37 (O'Connor, concurring), 791 (Breyer, concurring).

Only when the physician's intent shifts to causing death, and there is a direct causal relationship between conduct and result (in other words, no principle of double effect is at play) does the physician face potential criminal liability under Montana's deliberate homicide statute. See Mont. Code Ann. § 45-2-201 (describing causal relationship between conduct and result). In this respect, Montana physicians have no reason to fear prosecution for providing aid in dying through legitimate palliative care. Montana law criminalizes only a narrow category of activity, i.e., where the principle of double effect is not at work because the physician intends to affirmatively end life as opposed to providing aid in dying, or negligently departs from accepted standards of palliative care. The illusory nature of intent in this context is perhaps why there have been no criminal prosecutions in Montana for the conduct described by Plaintiffs. See Connor Aff., Ex. 4, ¶ 6.

The only known prosecution in Montana involving physician-assisted suicide is the case of State v. James Bischoff, Cause No. DC 29-04-23. (Ex. 4 ¶ 5.) Dr. Bischoff was charged with deliberate homicide after injecting one of his patients with drugs. The patient, who was suffering from congestive heart failure and had suffered a recent heart attack, was treated over the course of six days with escalating doses of Morphine and Ativan for respiratory distress and sleep. On the sixth day, Dr. Bischoff administered two different, short-acting drugs (Fentanyl and Versed), followed by a second round of the same drugs less than ten minutes apart. Ms. Dvarishkis was pronounced dead seven minutes later. (See Aff. of Probable Cause, attached as Ex. 5.) The State's experts opined that Dr. Bischoff intended to hasten death as opposed to relieve suffering

based on the type of drugs used, the quantity and timing of their administration, and the patient's almost immediate resulting death. (Cauglan Aff. Ex. 1, ¶ 17; Connor Aff. Ex. 4 ¶ .)

Plaintiffs' Claims

Plaintiffs are two patients without their own physicians, and four physicians without their own patients. Patient Plaintiff Baxter is at the end of his life in terms of the course of chronic lymphocytic leukemia. (Ex. 1, ¶ 14.) Patient Plaintiff Stoelb does not suffer from a terminal illness. Id. Instead, his medical records document a chronically depressed individual. Id. Good medical care can address his pain and disability, and hopefully his depression. Id.

Physician Plaintiffs are certified in the areas of internal medicine and family practice. None are board-certified in hospice and palliative medicine, psychiatry, anesthesiology, or any of its board-certified subspecialities including pain medicine. All agree that physicians have an ethical obligation to relieve pain and suffering and to promote dignity and autonomy of dying patients in their care, even if such care has lethal consequences. (Speckart Aff. ¶ 20; Risi Aff. ¶ 25; Loehnen Aff. ¶¶ 18-19; Autio Aff. ¶ 14.)

Plaintiffs want to go beyond palliative or hospice care, however. They seek an exception under the homicide statutes for what they term "aid in dying." As used in the Complaint, Plaintiffs contend that "aid in dying" means:

> the right of a mentally competent, terminally ill patient to obtain a prescription for a lethal dose of medication from a cooperating physician, which the patient may elect to self-administer to bring about a peaceful death."

(Pls.' Resp. to Interrog. No. 1, Ex. 3.) According to Plaintiffs, a person is "mentally competent" if he or she "understands what he or she is doing and the probable consequences of his or her acts." (Ex. 3, Pls.' Resp. to Interrog. No. 3.) Mental competence is determined by the person's attending physician regardless of his psychiatric qualifications. (Id.; Pls.' Resp. to Interrog. No. 2.) Consent to death requires nothing more than oral consent to a single physician without a witness. (Pls.' Resp. to Interrog. No. 6.) Plaintiffs do not require any kind of mental or psychological evaluation. The physician determining mental competence is the same physician providing the lethal prescription.

A person is "terminally ill" if he or she is 18 or older and has an "incurable or irreversible condition" that will result in death "in a relatively short time" that is largely undefined. (Ex. 3, Pls.' Resp. to Interrog. No. 4.) The definition is not limited to any specific illnesses, conditions or diseases. The relief sought is on behalf of all mentally competent, terminally ill adult patients who "face a dying process the patients finds intolerable." (Compl. at 8.) According to Plaintiffs, the degree of intolerance is completely subjective. (Ex. 3, Pls.' Resp. to Interrog. No. 5.) When combined with the vague definition of "terminally ill," it could allow mere depression or an otherwise treatable disease to qualify someone for physician-assisted suicide.

Patient Plaintiffs' conditions are susceptible to palliative care for the potential suffering they may encounter at the end of life. (Caughan Aff, Ex. 1, ¶¶ 9, 14.) Such palliative care has not been considered a crime in Montana. (Connor Aff, Ex. 4, ¶ 8.) Plaintiffs do not dispute this. (Ex. 3, Pls.' Resp. to Interrog. No. 13.) Thus, Plaintiffs' claims are not predicated on their inability to receive relief for their end of life suffering. Instead, Plaintiffs assert an interest not only in avoiding suffering and preserving dignity, but also being conscious of and for their deaths. (Autio Aff. ¶ 14; Loehnen Aff. ¶ 19; Risi Aff. ¶ 24.) Consequently, the remedy they seek is not to allow a physician to palliate suffering even when doing so may also cause death, a situation they concede is a "common practice . . . with a long tradition of acceptance in medicine" immunized by the doctrine of dual effect. (Risi Aff., ¶ 25; Speckart Aff., ¶ 20; see also Ex. 1, ¶ 11.)

In challenging the homicide laws, Plaintiff Physicians seek to cross the established boundary between non-criminal and criminal intent to affirmatively intend the death of their patients regardless of palliative effect. (Ex. 3, Pls.' Resp. to Interrog. No. 15.) In other words, despite the undisputed availability of palliative care to relieve their suffering, Plaintiffs want the right to commit, or become the victim of, homicide so that they may have the opportunity to hasten, and be conscious at, their own deaths. (Speckart Aff. ¶ 21.) Such physician-assisted suicide is inconsistent with the standard for palliative care in Montana and contrary to the

positions of mainstream health care professional associations in this and other countries. (Caughlan Aff. Ex. 1, ¶¶ 12, 18.)

ARGUMENT

The Montana Constitution does not contemplate or protect Plaintiffs' interest in physician-assisted suicide. There may be policy arguments, recognized by some foreign countries and the State of Oregon, in favor of allowing carefully regulated physician assisted suicide, but Plaintiffs and their counsel have chosen not to make those arguments to the people of Montana. While Montanans and their representatives recently and vigorously debated the Medical Marijuana Act (I.M. No. 148 (2004), Mont. Code Ann. §§ 50-46-101, et seq.), abolishing the death penalty (S.B. 306 (2007)), and even the definition of life itself (H.B. 403 (2007) & C.I. No. 100 (2008)), Plaintiffs have not even attempted to address their concerns through the legislative, initiative, or other political processes. (Pls.' Resp. to Interrog. No. 11, Ex. 3.) Despite the painful salience of end-of-life care for the vast majority of Montanans from all backgrounds (Pls.' Adm. Nos. 19, 20, Ex. 3), and the absence of interference by law enforcement in this arena (Pls.' Resps. to Interrog. Nos. 12, 13, Ex. 3, Connor Aff. ¶ 6-9, Ex. 4), Plaintiffs have bypassed this policy debate and brought it directly to the Courts. It does not belong here.

Plaintiffs have narrowed their constitutional claims to the Article II rights of privacy (section 10), equal protection (section 4), and individual dignity (section 4). While they apparently have abandoned their original claims under the rights of due process (section 17) and safety, health and happiness (section 3) (Compl., ¶ 26), the State moves for summary judgment on these claims too.

As Plaintiffs have explained, "[t]he facts in this case are straightforward and . . . unlikely to be seriously disputed." (Pls.' Br. at 4). Given that there is no genuine issue as to any material fact, the sole question before the Court is whether the Plaintiffs or the State "is entitled to a judgment as a matter of law." Mont. R. Civ. P. 56(c). The question for the court is one of law:

is the State constitutionally prohibited from enforcing the homicide laws in cases of physician assisted suicide?

As with other statutes, criminal statutes are entitled to a presumption of constitutionality unless they infringe upon a fundamental right. State v. Michaud, 2008 MT 88, ¶ 15, 342 Mont. 244, 180 P.3d 636. In the absence of a fundamental right, the party making the constitutional challenge bears the burden of proving, beyond a reasonable doubt, that the statute is unconstitutional. Michaud, ¶ 15. If the statute is found to regulate the exercise of a fundamental right, it must be justified by a compelling state interest and be narrowly tailored to that compelling interest. Gryczan v. State, 283 Mont. 433, 942 P.2d 112, 122 (1997), citing State v. Seigal, 281 Mont. 250, 934 P.2d 176, 183 (1997).

I. PLAINTIFFS LACK STANDING TO OBTAIN BLANKET IMMUNITY FROM THE HOMICIDE LAWS.

Plaintiffs begin their arguments with a discussion of standing. (Pls.' Br. 10.) They preemptively raise two standing arguments: First, that the Physician Plaintiffs have standing to litigate the rights of patients whose circumstances are not before the Court (Pls.' Br. 10); and second, that the Patient Plaintiffs have the right to litigate their claims even if they die during the course of the case. The State already has conceded the second argument to Plaintiffs, not because the Montana Supreme Court "bypass[es] the finer points of standing and mootness in order to decide constitutional issues" (Pls.' Br. at 12), but because, to the contrary, the Montana Supreme Court has, with due consideration, adopted the narrow rule of standing in controversies like this that are "capable of repetition, yet evading review." In re Mental Health of K.G.F., 2001 MT 140, ¶ 20, 306 Mont. 1, 29 P.3d 485. However, two standing problems remain.

A. Plaintiff Physicians Are Not Proper Representatives.

With respect to Plaintiffs' first argument concerning representative standing, the State acknowledges that based on the closeness of their relationship, health care providers may challenge statutes that, "by criminalizing certain procedures," "directly interdict the normal

functioning of the physician patient relationship." Armstrong v. State, 1999 MT 261, ¶ 12, 296 Mont. 361, 989 P.2d 364. Plaintiffs, however, are not in the same position as the physicians in Armstrong.

First of all, Plaintiffs do not challenge a statute that criminalizes a "certain procedure," such as the specific prohibition on physician assistants performing abortions. Armstrong, ¶ 24 (citing Mont. Code Ann. §§ 37-20-103, 50-20-109 (1995)). They challenge the more widely applied homicide statutes, as applied to an undefined set of procedures by which the Physician Plaintiffs would put an undefined class of patients to death by any means they choose. Where Armstrong presented a specific class of women in the pre-viability stage of pregnancy, the class eligible for physician assisted suicide is "not limited to any specific set of illnesses, conditions or diseases." (Ex. 3, Pls.' Resp. to Interrog. No. 4.) Where Armstrong presented a specific medical procedure in abortion, Plaintiffs have refused to limit themselves to any particular "type and dose of medication," which is left entirely to the physician's discretion. (Ex. 3, Pls.' Resp. to Interrog. No. 1.)

This is not merely a "fine point of standing." (Pls.' Br. at 12.) Absent such a specific set of facts as presented by the representative physicians in Armstrong, the Court can neither analyze the specific constitutional interests at issue, nor craft a specific constitutional remedy if one is required. Were Plaintiffs to prevail on their nebulous claims, the State would be enjoined from even investigating a suspicious death whenever a physician came forward to attest the deceased was terminally ill (regardless of any specific prognosis), consenting (regardless of the form of consent), and put to death through whatever means the physician chose (regardless of the risks that means may have posed). Equally important, if such a broad rule were ever constitutionalized in the way Plaintiffs want, the Legislature would be powerless to narrow it through regulation. This is a far cry from the clear guidance courts can provide in facial challenges such as Armstrong, where a single discrete statute is struck from the books in all its applications. See e.g., State of Arizona v. Sasse, 245 Mont. 340, 801 P.2d 598 (1990).

A related point follows from the conspicuous absence of the Patient Plaintiffs' treating physicians in this case. None of the Physician Plaintiffs have even attempted to assess the condition of the Patient Plaintiffs, at least one of whom may not meet the definition of "terminally ill" and whose depression may bring into question his alleged competency for and consent to physician assisted suicide on Plaintiffs' own terms. (Ex. 1, ¶ 14.) It, therefore, should raise a bright red flag that there is no "closeness of the relationship" among the Plaintiffs. Armstrong, ¶ 9, quoting Singleton v. Wulff, 428 U.S. 106, 117-18 (1976). Nor can Plaintiffs plausibly claim, even if they had established a relationship between the patients and the physicians at issue, that homicide represents the "normal functioning of the physician patient relationship." (Ex. 1 ¶¶ 12, 18.)

B. The Homicide Statutes Have Not Been Enforced Against Palliative Care in Montana.

There is another standing issue that would defeat Plaintiffs' claims, to the extent they fear state interference with purely palliative care rather than physician-assisted suicide. The homicide laws they challenge never have been applied to prevent terminally ill patients from receiving "aid in dying" in the form of necessary palliative care. (Connor Aff., Ex, 4, ¶ 9; Pls.' Resp. to Interrog. No. 13, Ex. 3.) When desuetude may present a barrier to standing, the Montana Supreme Court has only found standing to challenge "a criminal law aimed specifically at one group of citizens, the enforcement of which has not been disavowed by the state." Gryczan, 283 Mont. at 445, 942 P.2d at 119.

This is not such a challenge. Unlike the deviate sexual relations statute in Gryczan--which applied only to a specific minority group, was on the books for only 24 years, and was recently amended prior to the challenge with respect to the specific constitutionally protected conduct at issue--Montana has had a murder law on its books since territorial days. See 1879 Mont. Crim. Law, ch. 4, §§ 18-40. While the homicide law was reformed in 1973, none of the modernizations under that general criminal law update had the purpose or effect of targeting the conduct that is the basis of Plaintiffs' challenge.

Indeed, Gryczan specifically reserved the question of whether "100 years of nonenforcement may make a law so moribund that any fear of prosecution is imaginary." Gryczan, 283 Mont. at 443. Given the apparent absence of any homicide prosecution for "aid in dying" through palliative care in more than a century, and in the event Plaintiffs retreat from their primary claim of a right to physician assisted suicide, this case may present that reserved question.

II. THERE IS NO PRIVACY RIGHT IN ASSISTED SUICIDE.

Section 10 of the Declaration of Rights provides: "The right of individual privacy is essential to the well-being of a free society and shall not be infringed without the showing of a compelling state interest." There is no privacy right to physician-assisted suicide, whether derived directly from this Court's established privacy doctrine, or by analogy from other recognized privacy rights. Nor have other courts that have interpreted privacy clauses as strict or stricter than Montana's found such an interest. In any event, Montana's homicide laws serve the most compelling of state interests by protecting all persons, and especially the most vulnerable, from intentional killing and the denigration of the medical profession.

A. Montana Does Not Recognize a Privacy Interest In Physician-Assisted Suicide.

In cases addressing the "personal-autonomy privacy" at issue here, the Montana Supreme Court has analyzed the existence of a privacy interest under two different tests. The first test derives from the traditional form of informational privacy protected by the Fourth Amendment to the United States Constitution, and adopts the two-part analysis of Katz v. United States, 389 U.S. 347 (1967). This test requires "first that a person have exhibited an actual (subjective) expectation of privacy and, second, that the expectation be one that society is prepared to recognize as 'reasonable.'" Gryczan, 283 Mont. at 448, 942 P.2d at 121, quoting Katz, 389 U.S. at 361. The second test derives from the United States Supreme Court's development of substantive due process in the protection of certain liberty interests, and asks whether the statute

in question "violate[s] those 'fundamental principles of liberty and justice which lie at the base of all our civil and political institutions.'" Gryczan, 283 Mont. at 450, 942 P.2d at 122, quoting Palko v. Connecticut, 302 U.S. 319, 328 (1937).

Under either test, the privacy interest usually turns on whether society recognizes a privacy or a liberty interest in the conduct at issue. Gryczan, 283 Mont. at 451, 942 P.2d at 123. Plaintiffs have cited no case where a court has recognized a societal interest in physician assisted suicide sufficient to override the laws the states have enacted. Therefore, since it lacks objective reasonableness, Plaintiffs' privacy interest does not invoke constitutional protection.

To the contrary, Montanans have enacted laws reflecting a deeply rooted understanding that the practice of medicine is "to diagnose, treat, or correct human conditions, ailments, diseases, injuries, or infirmities." Mont. Code Ann. § 37-3-102(8). Causing death by any means is opposed to this understanding to such an extent that the execution of a death sentence is specifically exempted from the practice of medicine. See Mont. Code Ann. § 46-19-103. Even in the context of terminally ill patients, the law makes it "the responsibility of the attending physician, attending advanced practice registered nurse, or other health care provider to provide treatment, including nutrition and hydration, for a patient's comfort care or alleviation of pain." Mont. Code Ann. § 50-9-202(2); see also Mont. Code Ann. § 50-9-205(7) ("This chapter does not condone, authorize, or approve mercy killing or euthanasia.").

Plaintiffs assume rather than analyze the application of these privacy interest tests to physician-assisted suicide. Nowhere in their brief do they claim that adult Montanans "fully and properly expect" that their physicians will assist in their suicides, and if they do so "will not be subject to . . . governmental snooping or regulation." Gryczan, 283 Mont. at 450, 942 P.2d at 122. Nor do Plaintiffs claim that society is willing to accept such a radical change in the medical profession from healing and palliating to intentionally causing death. Id.

Instead, Plaintiffs simply assert "it is difficult to imagine the Supreme Court *not* recognizing the right" of physician assisted suicide. (Pls.' Br. at 26.) The Plaintiffs' "imagination" was not the basis of the privacy interests in Gryczan and Armstrong, and cannot

be the basis of a privacy interest in physician assisted suicide. Instead, the Court must find such an interest rooted in Montanans' real expectations of the role of government in their daily lives. Plaintiffs have offered no evidence of such an objective expectation of privacy.

B. Physician Assisted Suicide Is Not a "Lawful Medical Procedure" Protected By the Armstrong Privacy Interest.

Plaintiffs argue that Armstrong's analysis of physician-assistant provided abortion "applies directly to the issues now before this [C]ourt." (Pls.' Br. at 22.) They draw on the Montana Supreme Court's broadest formulation of "the right of each individual to make medical judgments affecting her or his bodily integrity and health in partnership with a chosen health care provider free from the interference of the government." Armstrong, ¶ 39; (Pls.' Br. at 23). However, as Plaintiffs later acknowledge, these medical judgments relate to "medical treatment;" they quote a decision addressing acupuncture and not physician assisted suicide to explain "it is the individual making the decision, and no one else, who, if he or she survives, ***must live with the results of that decision***." Armstrong, ¶ 54 (emphasis added), quoting Andrews v. Ballard, 498 F.Supp. 1038, 1047 (S.D. Tex. 1980); Pls.' Br. at 23. By its terms, this line of reasoning does not extend to a patient receiving physician assisted suicide, who cannot live with the results of the decision no matter how regrettable it may be in retrospect. The Montana Supreme Court's view of medical privacy in Armstrong properly aligns with society's view--treatment of the living, not intentional killing.

In fact, the privacy interest holding of Armstrong, consistent with Gryczan, is that "the procreative autonomy component of personal autonomy is protected by Montana's constitutional right of individual privacy found at Article II, Section 10." Id., ¶ 48. This follows from the special status accorded procreative and bodily autonomy in the abortion context. See Planned Parenthood v. Casey, 505 U.S. 833, 852 (1992) ("the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law."). Nothing in Armstrong suggests that physician-assisted suicide could be a corollary of this right to procreative autonomy. To the contrary, the Court limited the reach of the procreative privacy interest to infringements based on

"some intrinsic value ***unrelated to the protection of the rights and interests of persons with constitutional status***." Id., ¶ 68 (emphasis added). The homicide statutes Plaintiffs challenge are not just related to the protection of the rights and interests of persons with constitutional status; they are the primary protection of those same rights and interests. See Mont. Const. art. II, § 3 ("defending their lives" is an inalienable right).

Notably, as the Court has refined the Armstrong privacy interest through application in subsequent cases, it has emphasized the traditional medical function within the laws as they exist. Armstrong itself involved previability abortion, which was and is legal under Montana law. See Mont. Code Ann. tit. 50, ch. 20. According to the Court's own statement of Armstrong's holding:

> Armstrong described the right to health care as a "fundamental privacy right to obtain ***a particular lawful medical procedure*** from a health care provider that has been determined by the medical community to be competent to provide that service and who has been licensed to do so."

Wiser v. State, 2006 MT 20, ¶ 15, 331 Mont. 28, 129 P.3d 133, quoting Armstrong, ¶ 62 (emphasis added); cf. Mont. Supreme Court Comm'n on the Unauthorized Practice of Law v. O'Neil, 2006 MT 284, ¶ 53, 334 Mont. 311, 147 P.3d 200 (rejecting privacy claim to unregulated legal practice, distinguishing Armstrong's "autonomy right to obtain a lawful medical procedure from their chosen, licensed healthcare provider."). Thus, "it does not necessarily follow from the existence of the right to privacy that every restriction on medical care impermissibly infringes that right." Wiser, ¶ 15.

Perforce, it cannot follow from Armstrong that the homicide restriction on physician-assisted suicide--something the law does not even consider to be medical care--infringes on the privacy interest Armstrong identified. Even under a contorted view of physician assisted suicide as "medical care," as the Court explained in Armstrong:

> In narrowly defined instances the state, by clear and convincing evidence, may demonstrate a compelling interest in and obligation to legislate or regulate to preserve the safety, health and welfare of a particular class of patients or the general public from a medically-acknowledged, *bona fide* health risk.

Id., ¶ 59. As discussed above and proven by the Bischoff case, the homicide statute plays a critical role in preserving the safety, health, and welfare of the particularly vulnerable class of terminally ill patients. As Montana recently recognized by enacting a suicide prevention program, Mont. Code Ann. § 53-21-1102, suicide is a medically-acknowledged, *bona fide* health risk.

C. Other State Courts Have Refused to Sanction Assisted Suicide Despite Similar State Constitutional Privacy Provisions.

Like Montana, both Florida and Alaska have expressly declared the right of privacy in their state constitutions. Fla. Const art. I, § 23 ("Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein..."); Alaska Const art. I, § 22 ("The right of the people to privacy is recognized and shall not be infringed."). When confronted with the question of whether assisted suicide is a protected right under these privacy provisions, both state supreme courts answered "no." The Florida Court refused to expand the "right to die" to include aid in dying in the form of assisted suicide because, no matter how well intended, it involved an "affirmative act designed to cause death." Krischer v. McIver, 697 So.2d 97, 102 (Fla. 1997).

The Alaska Supreme Court reached a similar conclusion in Sampson et al. v. Alaska, 31 P.3d 88 (Alaska 2001), which upheld the state's manslaughter statute against constitutional attack on privacy grounds. The Alaska Court noted the practical problems of a judicially created exception, particularly with respect to determining mental competency:

> [B]y proposing to restrict physician-assisted suicide to mentally competent adults, [Plaintiffs] would hinge the exercise of that right on a vague, unverifiable, and subjective standard. While mental competency is certainly well accepted as a measure for determining when physicians may render life-prolonging medical treatment, it is potentially far more controversial as a measure for determining when a physician is entitled to terminate a patient's life. This is so not only because the prescription of life-ending medication is a unique and absolute form of medical "treatment," but also because the mental competency of terminally ill patients is uniquely difficult to determine.

Id. at 97.

Similar concerns were expressed by other courts presented with the question of physician-assisted suicide. See Donaldson v. Lundgren, 4 Cal. Rptr. 2d 59 (Cal. Ct. App. 1992);

Michigan v. Kevorkian, et al., 527 N.W.2d 714, 727 (Mich. 1994), cert. denied, 514 U.S. 1083 (1995) ("Because all persons possess a basic right to personal autonomy, regardless of their physical or mental condition, there would be no principled basis for restricting a right to commit suicide to the terminally ill. The inevitability of death adds nothing to the constitutional analysis.")

Importantly, the Alaska court differentiated Sampson from a privacy-based abortion case, Valley Hospital Ass'n v. Mat-Su Coalition for Choice, 948 P.2d 963 (Alaska 1997), just as the privacy interests in this case differ from the privacy interest in Armstrong. The Alaska Supreme Court limited Valley Hospital's privacy protections to reproductive decisions, because "[t]he manslaughter statute's assisted suicide prohibition regulates the conduct of the physician who assists in a suicide, not the conduct of the patient who commits the suicide. And a physician who assists in a suicide undeniably causes harm to others." Id. at 95.

These Courts left open the possibility that their respective state legislatures would craft a procedure for physicians as a matter of social policy, but refused to find the right as a matter of constitutional law. Like the United States Supreme Court, these courts encouraged, rather than preemptively ended, the debate about "the morality, legality, and practicality of physician-assisted suicide" at the state level, noting that nothing in its opinion foreclosed states from crafting PAS laws as a matter of social policy. Washington, et al. v. Glucksberg, et al., 521 U.S. 701, 735-36 (1997).

D. The Statutes in Question Are Narrowly Tailored to Meet the State's Compelling Interests.

The homicide statutes provide a bright-line distinction between illegal conduct (assisted suicide) and legal conduct (palliative care), based on the intent of the actor. Plaintiff Physicians seek the right to cross that bright line, notwithstanding the availability of palliative care under the double effect doctrine, and affirmatively cause death with criminal intent. That line is narrowly drawn within constitutional bounds for deliberate homicide, as well as mitigated deliberate

homicide and negligent homicide, to serve compelling state interests in protecting society against the evils of intentional killing without infringing on the patient's constitutional rights.

"[A] compelling state interest exists where the state enforces its criminal laws for the benefit and protection of other fundamental rights of its citizens." State ex rel. Zander v. District Court of Fourth Judicial Dist., 180 Mont. 548, 556, 591 P.2d 656, 660 (1979). First and foremost, the homicide statutes evidence the State's longstanding commitment to protecting and defending life. Mont. Const. art. II, §§ 3, 17; Glucksberg, 521 U.S. at 729-30.

Second, the State has a compelling interest in protecting vulnerable groups such as the elderly, the disabled, or the terminally ill, from potential abuses associated with physician-assisted suicide. See State v. Mount, 2003 MT 275, ¶ 99, 317 Mont. 481, 78 P.3d 829 (sex offender statute justified by compelling state interest in protecting the public, and particularly vulnerable children); see also Glucksberg, 521 U.S. at 719, 731, citing the New York Task Force on Life and the Law 120 ("the risk of harm is greatest for the many individuals in our society whose autonomy and well-being are already compromised by poverty, lack of access to good medical care, advanced age, or membership in a stigmatized social group.") As Justice O'Connor observed in her concurring opinion in Glucksberg:

> The difficulty in defining terminal illness and the risk that a dying patient's request for assistance in ending his or her life might not be truly voluntary justifies the prohibition on assisted suicide we uphold here.

Id., 521 U.S. at 738; see also Donaldson, 4 Cal.Rptr. 2d at 64 ("The state's interest must prevail over the individual because of the difficulty, if not the impossibility, of evaluating the motives of the assister or determining the presence of undue influence.").

Third, the State also has an interest in protecting the integrity and ethics of the medical profession. Glucksberg, 521 U.S. at 731; Sampson v. State, 31 P.3d at 96. The AMA has concluded that "physician assisted suicide is fundamentally incompatible with the physician's role as healer." AMA Code of Medical Ethics, § 2.211 (1994), cited in Glucksberg, 521 U.S. at 731. Absent specific guidelines for medically sound decision-making, many doctors do not desire the power to control the timing of death. (Caughlan Aff. ¶ 15, Ex. 1.) Even when life is

nearing its end, the State has an interest in encouraging care rather than the option of suicide. Instituting a right to assisted suicide might have the opposite intended effect by reducing the incentive to create better ways to help the sick and dying. See Carl E. Schneider, Law at the End of Life at 191, University of Michigan Press (2003) (noting that, in the Netherlands, where physician assisted suicide is legal, hospice care is virtually nonexistent. Id.; cf. Ex. 1 ¶ 16.

Plaintiffs also claim a right to physician assisted suicide under extreme mental emotional stress, or through negligence. (Ex. 3, Pls.' Adm. Nos. 10, 12.) They offer no argument for these rights. The former may be grounds for the revocation or suspension of the Plaintiff Physicians' licenses. Compare Mont. Code Ann. § 45-5-103 with Mont. Code Ann. § 37-3-323(1) ("a condition that impairs the person's intellect or judgment to the extent that the condition incapacitates the person for the safe performance of professional duties."). The latter amounts to malpractice. See Mont. Code Ann. § 27-6-103(5) (defining medical malpractice claim). The State is aware of no authority for transforming what would be professional misconduct in a normal instance into constitutionally protected conduct when that misconduct results in death. Even were there a constitutional right to obtain carefully regulated physician-assisted suicide--something Plaintiffs have not proposed or prayed for--such a right would not extend to physicians who are incompetent by reason of extreme passion or want of ordinary care. See Wiser, ¶ 20 (rejecting fundamental "right to obtain medical care free of regulation."); see also Armstrong, ¶ 62.

III. THE HOMICIDE LAWS DO NOT DISCRIMINATE AGAINST A PROTECTED CLASS.

Section 4 of the Declaration of Rights provides in part: "No person shall be denied the equal protection of the laws. Neither the state nor any person, firm, corporation, or institution shall discriminate against any person in the exercise of his civil or political rights on account of race, color, sex, culture, social origin or condition, or political or religious ideas." The function of this clause is "to protect different groups of persons who were prosecuted and abused for

simply being who they were born to be," such as racial and religious minorities and women. Snetsinger v. Mont. Univ. Sys., 2004 MT 390, ¶ 60, 325 Mont. 148, 104 P.3d 445.

The first step in analyzing an equal protection challenge is to identify the classes involved and determine whether they are similarly situated. Snetsinger, ¶ 16. Here Plaintiffs' claim falters on their admissions that terminal illness strikes or directly affects a majority of individuals without regard to race, color, sex, age, culture, social origin and condition, and political and religious ideas. (Ex. 3, Pls.' Adm. Nos. 19, 20.) In other words, the relevant class is all adult Montanans who are, or may become, terminally ill. That is, the class is all adult Montanans.

The universal scope of Plaintiffs' proposed classification shows it to be a misuse of the equal protection clause's minority-protective function. The homicide statutes hardly are an instance "where the legislature has codified the morals of the majority and seeks to impose them upon citizens with a different view." (Pls.' Br. at 14.) To the contrary, Plaintiffs estimate that four out of five Montanans will suffer a slow-acting terminal illness (e.g., cancer, lung disease, heart failure) that could qualify a person for physician assisted suicide under their theory. (Pls.' Br. at 6.) Thus, the homicide statute cannot be considered "a device designed to impose different burdens on different classes of persons." State v. Spina, 1999 MT 113, ¶ 85, 294 Mont. 367, 982 P.2d 421 ("To prevail on an equal protection claim, an injured party must first be able to demonstrate that the law or governmental action at issue discriminates by impermissibly classifying persons and treating them differently on the basis of that classification.") quoted in Snetsinger, ¶ 16.

Faced with a lack of discrimination in the homicide laws they challenge, Plaintiffs argue instead that it is unconstitutional for the State to allow physicians to withhold or withdraw life support for terminally ill persons under the Rights of the Terminally Ill Act, while prohibiting physicians from causing the death of terminally ill persons through physician assisted suicide. (Pls.' Br. at 32.)

This argument proves both too little and too much. It proves too little because there is a constitutionally defensible line between an action and an omission, between allowing natural

causes to run their course and becoming an agent of death itself. Cruzan, 497 U.S. at 278-79. Where, as here, the groups at issue do not constitute similarly situated classes, an equal protection challenge must fail. Bean v. State, 2008 MT 67, ¶ 13, 342 Mont. 85, 179 P.3d 524. "[T]he distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical; it is certainly rational." Vacco, 521 U.S. at 801 (footnote omitted).

It proves too much because, as Plaintiffs admit, there is an unknown number of terminally ill patients who cannot "benefit" from Plaintiffs' proposed version of aid in dying because they are unable to self-administer the physician's lethal dose, or for some other reason unrelated to mental competence. (Ex. 3, Pls.' Resp. to Interrog. No. 9.) Here, Plaintiffs have shown the Court the first few steps beyond the action-omission line and down the slippery slope from physician assisted suicide to euthanasia. If choosing the time and manner of one's own death is a fundamental right under the Montana Constitution, then it cannot belong only to the able-bodied patients who can take a lethal dose of medicine orally. It also must belong to the significant class of disabled patients who can request physician assisted suicide but cannot themselves commit the final act. See Glucksberg, 521 U.S. at 733; Lee v. Oregon, 869 F.Supp. 1491 (D. Ore. 1994) (discussing equal protection implications of Oregon's statutes limiting physician-assisted suicide to terminally ill, mentally competent adults). This necessary nondiscriminatory extension of Plaintiffs' aid-in-dying right to the disabled would commandeer physicians into administering the fatal dose personally, a consequence Plaintiffs may deem too unseemly to articulate in their requested relief.

In any event, Plaintiffs' attempted equal protection analogy between withdrawal of life support and physician assisted suicide does not obtain their desired result. The classification that their equal protection claim attacks is not made by the homicide law, but by the Rights of the Terminally Ill Act. So the result of a successful challenge would not be a new judge-made aid-in-dying procedure; instead, it would result in striking down the classification imposed by the Rights of the Terminally Ill Act. See Bean, ¶ 28 (Cotter, J., concurring) (in equal protection

challenge, granting relief to class that lacked a new legal benefit would require denying the new benefit to another class instead of conferring the new benefit on the Plaintiff class). This would be a step back, not forward, for the rights of the terminally ill that Plaintiffs seek to vindicate.

IV. THERE IS NO DIGNITY RIGHT IN ASSISTED SUICIDE.

Section 4 of the Declaration of Rights, in addition to the equal protection guarantee, also provides: "The dignity of the human being is inviolable." While Plaintiffs claim "that individual dignity is a fundamental, freestanding right" (Pls.' Br. at 30), the Montana Supreme Court has been more equivocal. All of the cases Plaintiffs cite for the "freestanding right" of dignity involve other primary rights that are the focus of the Court's constitutional interpretation in each decision. See Walker v. State, 2003 MT 134, ¶ 73, 316 Mont. 103, 68 P.3d 872 (reading dignity clause together with cruel and unusual punishment prohibition); K.G.F., ¶ 45 (invoking dignity clause through statutes contained within a due process analysis); Armstrong, ¶¶ 71-72 (dignity clause part of "overlapping and redundant rights and guarantees").

Moreover, despite the weight Plaintiffs place on the "absolute liability" principle they find in the modifier "inviolable," they cite no case in which a Court has imposed such liability notwithstanding the State's interests. (Pls.' Br. at 30.) In fact, the dignity clause "model" Plaintiffs would have this Court adopt has been adopted by a single justice of the Montana Supreme Court, and then only as an extension of the equal protection clause's bulwark against invidious discrimination by the majority aimed at an unpopular minority. See Snetisinger, ¶ 75 (Nelson, J., concurring).

The terminally ill possess the same dignity held by all Montanans. However, it is unclear how the dignity clause should lead a Court to lower the standards for physicians who care for this especially vulnerable population by introducing a lethal ambivalence to the physician's traditional caretaking role. Those cases in which the dignity interest has sounded most strongly involve mentally ill persons and require the intensification of protective efforts on their behalf, rather than the sudden cessation of care implicit in physician-assisted suicide. See Walker, ¶ 81

(requiring that basic human needs be met for imprisoned mentally ill persons, including adequate medical care, ***to help avoid petitioner's suicide***); K.G.F., ¶ 90 (requiring specific services by counsel for the mentally ill in involuntary commitment proceedings).

The dignity cases also require heightened due process protections for decisions made by or on behalf of a vulnerable person. For example, K.G.F. sets forth a detailed process to appoint counsel for involuntary commitments, and established a presumption of ineffective assistance of counsel in the absence of evidence of voluntary and knowing consent. Id., ¶ 88. Plaintiffs would turn these due process protections on their head, allowing a patient's life-or-death decision to be made unrecorded, by a victim of depression, and based solely on the "professional judgment" of a single physician who has no psychiatric qualifications and is not the patient's treating physician. (Ex. 3, Pls.' Resp, to Interrog. Nos. 3, 10; Pls.' Adm. No. 21; Autio Aff. ¶ 16; Loehnen Aff. ¶ 21; Risi Aff. ¶ 27; Speckart Aff. ¶¶ 23, 27).

Such a process as Plaintiffs propose, if it can be called a process, should heighten rather than reduce the dignity clause concerns of a Court that was "cautious and critical" of health professionals who "purport to have an absolute understanding of what is in the best interests of an individual, whose liberty, dignity and privacy are at issue, and whose voice is muted by the swift and overriding authority" of those same professionals. K.G.F., ¶ 62. In that case, at least, the professionals were court-appointed in a case-by-case judicial process, unlike the Plaintiff Physicians here, who ask for a single judicial approval of physician assisted suicide on behalf of all physicians and all terminally ill Montanans now and in the future.

V. THE HOMICIDE LAWS DO NOT VIOLATE DUE PROCESS.

Section 17 of the Declaration of Rights provides that: "No person shall be deprived of life, liberty, or property without due process of law." This clause has both a procedural and a substantive component. Substantive due process bars arbitrary government actions regardless of the procedures used to implement them, and serve as a check on the oppressive governmental action. State v. Egdorf, 2003 MT 263, ¶ 19, 317 Mont. 436, 77 P.3d 517. A substantive due

process analysis requires an examination of underlying substantive rights and remedies to determine whether restrictions are unreasonable or arbitrary when balanced against the purpose of the legislature in enacting the statute. Id.

As discussed in Part II, above, the legislature's general interest in deterring suicide and intentional killing since before statehood is a compelling one, reflecting the long-established expectations of Montanans that the State will protect their lives and that physicians will not kill. The homicide statutes do not infringe in any way upon the right of a terminally ill, mentally competent patient (or even a terminally ill, mentally incompetent patient) to receive aid in dying in the form of palliative care. Given the availability of palliative care, there is nothing unreasonable or arbitrary in proscribing intentional killing in all circumstances, including the end of life.

Plaintiffs may have backed away from their due process claim given the weight of well-considered authority against it. After receiving and considering an extraordinary volume of argument and background from dozens of briefs from parties and learned amici curiae (including the State of Oregon), the United States Supreme Court rejected a due process right to commit suicide with assistance of another in Glucksberg. In Glucksberg, a group of physicians, individuals, and a nonprofit organization sought a declaratory judgment and injunctive relief to bar the State of Washington from enforcing a statute making it a felony to knowingly aid another in committing suicide. The United States Supreme Court found no historical support for the proposition that the right to commit suicide, let alone the right to assistance in committing suicide, is a protected liberty interest. Id., 521 U.S. at 735. Justice Breyer noted the sufficiency of palliative care to address the core interest of "dying with dignity," because the laws at issue "do not prohibit doctors from providing patients with drugs sufficient to control pain despite the risk that those drugs themselves will kill." Id. 521 U.S. at 791.

Plaintiffs have offered no evidence or argument to contradict the United States Supreme Court's thorough analysis of the due process issue. As discussed in Part IV above, Plaintiffs'

unregulated and unaccountable version of "aid in dying" raises serious due process concerns rather than resolving them.

VI. PHYSICIAN-ASSISTED SUICIDE DOES NOT VINDICATE "SAFETY, HEALTH, AND HAPPINESS."

Plaintiffs do not, and could not, contend that physician-assisted suicide is one of the inalienable rights protected by the Montana Constitution's guarantee of the right to seek "safety, health and happiness in all lawful ways." Mont. Const. art. II, § 3. This nebulous constitutional right, while ensuring a Montanan's right to aspire to whatever lifestyle that person wishes, importantly limits those aspirations to only otherwise legal activities. Wiser, ¶ 21. Article II, section 3 is not a constitutional right to anarchy. The Supreme Court has not explicitly held a guaranteed, self-executing right in "safety, health, and happiness," but instead has used Article II, section 3, to emphasize the meaning of other fundamental rights. See, e.g., Gryczan, ¶ 72.

Montana has never recognized physician-assisted suicide to be lawful. For that reason, no claim to physician-assisted suicide founded in article II, section 3 exists. Death makes a patient less safe to the ultimate degree, less healthy to the ultimate degree, and less happy to the ultimate degree. For the reasons discussed above, the proposition that assisted suicide promotes safety, health or happiness entirely ignores the risk involved when physicians are empowered to commit homicide.

VII. THE COURT SHOULD DECLINE PLAINTIFFS' INVITATION TO DECLARE ASSISTED SUICIDE AS THE PUBLIC POLICY OF THIS STATE.

As an alternative remedy, Plaintiffs ask this Court to declare that "the public policy of Montana is to allow aid in dying despite the fact that it accelerates the timing of an individual patient's death[.]" (Pls.' Br. at 9-10.) According to Plaintiffs, this would allow physicians to invoke the defense of consent in Mont. Code Ann. § 45-2-211(2)(d), and thereby "be immunized from prosecution." (Pls.' Br. at 9.) The consent defense is inapplicable when "it is against public policy to permit the conduct or the resulting harm."

Affirmative defenses, including consent, do not insulate a person from criminal prosecution. Rather, they provide a legal defense to the crime charged. Mont. Code Ann. §§ 45-2-211, -212, -213; see e.g., State v. Root, 1999 MT 203, 296 Mont. 1, 987 P.2d 1140. Preclusion of criminal prosecution based on judicially declared policy raises separation of powers issues that preclude the relief Plaintiffs seek through declaratory judgment or injunction. See State ex rel. Fletcher v. District Court, 260 Mont. 410, 414-15, 859 P.2d 992, 996-97 (1993) (a court may not interfere with the prosecutorial function without violating the separation of powers embodied in Mont. Const. art. III, § 1).

Moreover, Plaintiffs cite, and the State has found, no case in which a court has recognized a consent defense to homicide. In fact, the opposite is true. See 1 F. Wharton, Criminal Laws, § 46 (15th Ed. 1993). The public policy of Montana is to require written consent for extended service contracts, land sales, and real estate brokerage commissions (see Mont. Code Ann. § 28-9-903), and two witnesses in writing for standard wills (see Mont. Code Ann. § 72-2-522), yet Plaintiffs would allow a person to dispose of life itself without any of the traditional procedural guarantees of informed consent. This contradicts the well-established duties of informed consent. See Collins v. Itoh, 160 Mont. 461, 467-68, 503 P.2d 36, 40 (1972) (recognizing "[t]he duty to disclose to assure that an informed consent is obtained" for a medical procedure); see also Armstrong, ¶ 57, citing same. Indeed, their contemplated oral consent to a single doctor provides far fewer procedural protections than other jurisdictions that have implemented physician-assisted suicide. Ex, 1, ¶ 16.

Finally, the public policy of Montana sufficiently recognizes Plaintiffs' asserted interests in avoiding suffering at the end of life through the common law doctrine of double effect in the administration of palliative care. (Ex. 2.) Plaintiffs admit that this doctrine enjoys "a long tradition of acceptance in medicine" (Risi Aff. ¶ 25), and the State has recognized it in practice. (Ex. 1 ¶9; Ex. 4 ¶ 9). For the public policy reasons already discussed, this Court should decline Plaintiffs' invocation of a consent defense to homicide outside of an ongoing prosecution.

CONCLUSION

For the foregoing reasons, the State respectfully requests the Court to grant summary judgment to the State, and deny summary judgment to the Plaintiffs.

Respectfully submitted this 1ST day of August, 2008.

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CERTIFICATE OF SERVICE

I hereby certify that I caused a true and accurate copy of the foregoing Defendant's Cross-Motion for Summary Judgment and Combined Principal and Response Brief to be mailed to:

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Exhibit 1

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COUNSEL FOR DEFENDANTS

MONTANA FIRST JUDICIAL DISTRICT COURT
LEWIS AND CLARK COUNTY

ROBERT BAXTER, STEVEN STOELB, STEPHEN SPECKART, M.D., C. PAUL LOEHNEN, M.D., LAR AUTIO, M.D., GEORGE RISI, JR., M.D., and COMPASSION & CHOICES, Plaintiffs, v. STATE OF MONTANA and MIKE McGRATH, Defendants.	Cause No. ADV 2007-787 **AFFIDAVIT OF DR. THOMAS V. CAUGHLAN**

STATE OF MONTANA)
: ss.
County of Flathead)

THOMAS V. CAUGHLAN, upon his oath, deposes and says:

A. BACKGROUND INFORMATION

1. My name is Thomas Vaughn Caughlan, M.D. I am a medical doctor who received his medical degree from the University of Iowa in 1976. I finished my Internal Medicine residency at the University of Iowa in 1979.

2. I was a member of the Dean Medical Center in Madison, Wisconsin,

as well as an Associate Professor of Internal Medicine at the University of Wisconsin, from 1980 to 1986. From 1986 to 1988, I was a member of the Aspen Medical Group in the Minneapolis, St. Paul area. From 1988 through the present, I have been in private practice in General Internal Medicine in Kalispell, Montana.

3. For the last 18 years, I have been the Medical Director of Home Options Hospice. The Hospice serves about 350 people per year. My duties include attending to weekly Hospice team meetings and being available for inpatient palliative care consultations or inpatient Hospice care, as well as providing assistance to the nurses providing Hospice care in the home.

4. I am Board Certified in Internal Medicine as well as Geriatrics and Hospice and Palliative Medicine.

5. I am licensed to practice medicine in the State of Montana and have been licensed as well in the states of Iowa, Illinois, Minnesota, and Wisconsin.

6. I hold staff privileges at both Kalispell Regional Medical Center and North Valley Hospital.

B. ASSIGNMENT IN THIS CASE

7. I was asked by the Attorney General's office to review the case medical files and other relevant materials including the medical literature, professional association guidelines and medical ethics literature. I have reviewed those materials, as well as the Complaint and Plaintiffs' Responses to State of Montana's First Discovery Requests. I was asked to explain palliative care as it is practiced in Montana and its relationship to the equality, autonomy, dignity, health, safety and happiness of the individual patient at the end of their life. I was asked to differentiate between palliative end of life care and "aid in dying" as put forward by the Plaintiffs, and to address the impact of "aid in dying" on the delivery of end of life care in Montana, the physicians who provide it and the terminally ill patients who receive it.

C. END-OF-LIFE CARE IN MONTANA

8. Palliative care is intended to relieve pain and suffering. A patient's symptoms may include, beyond pain, shortness of breath, nausea, decreased appetite, weakness, delirium, depression, and spiritual suffering. Acute aggressive treatment of underlying disease shouldn't preclude palliative care. The treatment of any physical symptoms should be a part of the treatment plan for all seriously ill patients, not just those who qualify for Hospice or those who accept that they are dying. Inpatient palliative care units are in development in hospitals throughout the country. Hospice provides care in certain end-of-life situations. It requires that two physicians are able to determine that the patient has six months or less to live and also that the patient is accepting that they are at the end of life and are willing to forego any further aggressive medical therapy to prolong their lives. Typical patients receiving hospice care include patients who have failed treatment for their cancer; patients who are showing progressive debility and decline with weight loss; patients with end stage lung diseases such as emphysema; end stage cardiac diseases such as congestive heart failure; and end stage neurological diseases such as amyotrophic lateral sclerosis. Frequently, these patients also suffer from depression with surveys indicating that up to 50 percent of patients on Hospice are clinically depressed. The diagnosis of depression can be difficult in this setting, because the usual symptoms of depression, including sleep disturbance, lassitude, loss of joy, weakness, weight loss, are all typically concomitant to the underlying illness.

9. The practice of palliative and Hospice medicine are the most challenging and difficult clinical situations that a physician encounters. The symptoms and suffering of the patients can be extraordinary. The kinds of drugs employed and the doses used are staggering and, at times, terrifying even to those of us who treat these problems on a regular basis. These include opiates of all kinds,

administered intravenously, subcutaneously, transdermally, orally, and intrathecally, as needed to control pain. Anticholinergic drugs are used to help dry secretions in people with respiratory problems. Antiemetic drugs are used at high doses, often in combination. Benzodiazepine drugs are used in a variety of modes (not unusually at high doses) to help with the anxiety associated with end of life. Major tranquilizers (antipsychotics) are often employed to help diffuse the symptoms of delirium. When I meet with a patient and family, I routinely promise them that the patient will not die in pain, and I think I have been able to keep that promise. A survey of oncologists revealed that the more comfortable the physicians felt in providing palliative care, the more confident they were that they could manage their symptoms. Emanuel E., Fairclough, D., et al., Attitudes And Practices Of U.S. Oncologists Regarding Euthanasia and Physician assisted Suicide; Ann. Intern. Med. 2000, 133:527-532.

10. The modern Hospice movement has been in existence since the 1950s when it was started in London, England. It has been prominent in the United States since the 1980s with, at last count, to my knowledge, greater than 4,000 Hospices across the nation. Hospice and palliative medicine has been addressed as a specialty that is Board certifiable by the American Board of Medical Specialties and fellowships are being developed for formal clinical training.

11. In palliative care, the provision of medications (usually opiates) to the imminently dying is the most common example of action that falls under the rule of "double effect." This is an ethical term that dates back to the Middle Ages. The rule of "double effect" is the constant that provides ethical and legal justification to a variety of actions that may cause both wanted and unwanted consequences. The desired effect of palliative care is to relieve pain, and the unwanted consequence may be hastened death (through respiratory depression). The rule of "double effect" means that palliative (or terminal) sedation is an

accepted practice and is consistent with end-of-life care as practiced in almost all hospices in the world. The rule relies heavily on the intent of the clinician. For example:

> A terminally ill man experiences unrelenting pain and suffering, asks his physician for help in ending his misery. If the physician kills the patient to end his suffering, the patient's death is intended. According to the rule of "double effect", the goal of relieving the patient's pain and suffering is good, but the means chosen to achieve the goal is wrong within the moral system that prohibits the intentional killing of innocent persons.

Slumasy, D.P., Peligrino, E.D., The Rule of Double Effect: Cleaning Up the Double Talk, Arch. Intrn. Med. 1999; 159:545-550.

12. "Aid in dying" as described in the Plaintiffs' documents seems to describe a very narrow part of end-of-life care, which can be best described as physician assisted suicide or PAS. Aid in dying is a very broad concept that includes lay societies that provide assistance in dying, as well as situations where medical professionals give assistance to patients at the end of life. The "aid in dying" described by plaintiffs is inconsistent with palliative care. There is no monitoring or titration of medication because the patient self-administers the drug. The physician may or may not be present when that occurs. It is anticipated that the patient would take a single, fatal dose, as opposed to escalating doses over time. It appears that the doctor would provide specific instruction on use of the medication to cause death, not to relieve pain or suffering. The medication would be dispensed in amounts pre-determined to cause death, not to relieve discomfort or to sedate. Unlike palliative care, where the physician evaluates and responds to the patient's need to control discomfort and other symptoms at the end of life, these physicians would be responding to a patient's direct request to die. In the former situation, the physician is treating the patient, even though that treatment may itself hasten death. In the latter situation, the patient is actively seeking the physician's assistance in

committing suicide.

D. PLAINTIFFS' MEDICAL CONDITIONS

13. The commonly accepted definition of "terminally ill" is someone who has six months or less to live. Indeed, in order to qualify for a Hospice benefit from Medicare, Medicaid or private insurance coverage, a patient must be determined to have six months or less to live and typically that determination needs to be made by the patient's treating physician, as well as the Medical Director of the local Hospice. This is a very difficult issue. Very frequently, patients are given an extension of the Hospice benefit beyond six months; sometimes many extensions. Occasionally, patients are even discharged from Hospice because they demonstrate little progression towards end of life.

14. By standard medical criteria, Mr. Baxter certainly is at the end of his life in terms of his chronic lymphocytic leukemia course. Mr. Stoelb, however, does not suffer from a terminal illness. Ehlers Danlos (ED) syndrome is a chronic debilitating illness which inflicts chronic pain and disability upon patients who have inherited this disease. There are seven different sub-types of ED. Mr. Stoelb suffers from classic Type I ED. This is not a fatal disease. The limited medical records in Mr. Stoelb's file document a chronically depressed individual. Good medical care can address his disability and pain and, hopefully, his depression. The prescription for a fatal dose of medication by a physician to treat his despair is inappropriate, in my opinion.

E. IMPLICATIONS OF AID IN DYING FOR END OF LIFE CARE IN MONTANA

15. The injunctive relief that the Plaintiffs are seeking in this case is essentially aimed at the legitimatization of PAS, which is a small subset of aid in dying. There are many implications for physicians and their patients with the application of PAS. The effects upon patient autonomy, dignity, health, and

happiness, as well as the physician-patient relationship and adequate provision of end of life care are numerous:

(1) If suffering is truly what leads persons to support PAS, then the category of what counts as "unbearable suffering" is flexible enough to permit expansion beyond terminally ill patients. Indeed, this has happened in the Netherlands where voluntary active euthanasia has been legalized. In a comprehensive 1990 survey, the Dutch government found that physicians performed PAS for large numbers of patients without terminal diagnoses (or consent, for that matter). (van der Mas, P.J., van der Wal, G., et al., Euthanasia, Physician Assisted Suicide and Other Practices Involving the End Of Life in the Netherlands, 1990-1995. N. Engl. J. Med.1996;.335:1699-1705.);

(2) Of interest, these physicians provided PAS for less than on-third of the patients who requested it. For most of the other two-thirds, they found alternatives which made life "bearable again" (the Dutch criteria for suicide/euthanasia is "unbearable suffering," not necessarily physical suffering);

(3) If PAS is to be limited only to the terminally ill, problems arise from the physician's inability to accurately identify who is truly terminally ill. As mentioned earlier, the determination of prognosis, even for admission to Hospice, is fraught with inaccuracy;

(4) If PAS is to be limited only to patients who are competent, problems can arise when competency and capacity to make sound decisions are difficult to assess and define. As has been seen with some patients with early Alzheimer's, particularly as seen with the Kevorkian experience in Michigan, patients may seek to end their lives sooner if there is a perceived danger to them that competency may evaporate as their illness progresses.

F. LESSONS FROM OREGON

16. Physician-assisted suicide has been available for the terminally ill

(those with less than six months to live) to Oregonians since 1997 under the Death with Dignity Act. Much has been learned through the Oregon experience over the ensuing decade. On average, about 50 people commit suicide a year in Oregon with PAS and greater than 100 request medications from their physicians for physician-assisted suicide. The Oregon law allows physicians to prescribe, but not administer, medications that can be used to end life. The person requesting the prescription must: (1) be an adult, (2) be capable, (3) be a resident of Oregon, (4) have been determined by the attending physician and a second consulting physician "to be suffering from a terminal disease," (5) "have voluntarily expressed his or her wish to die," and (6) "make[s] a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with the law." Physicians must report all prescriptions for lethal medications to the Oregon Department of Health Sciences. Physicians are protected from criminal prosecution if they adhere to the requirements of the law. Surveys have demonstrated that the majority of patients in Oregon seeking physician-assisted suicide did so not because of pain, but loss of dignity as they define it, isolation, loneliness, fear, anxiety, expectations of others and the desire not to be a burden or cause of sorrow for friends and family. Greater than 80 percent of the patients requesting PAS are enrolled in Hospice. The true lesson from Oregon is that they have evolved to become the most progressive state in the nation in the promotion of Hospice and palliative care with the highest rate of Hospice referral and the highest use of morphine per capita in end of life care. This reflects the wide public debate and discussion over the many years of the legalization process, rather than the passage of the Death with Dignity Act itself.

G. <u>THE BISCHOFF CASE</u>

17. In 2004, I was asked by the Attorney General to render an expert opinion in a case of deliberate homicide brought against a physician in Montana,

Dr. James Bischoff. I reviewed 42 separate medical records attended to by Dr. Bischoff. In 29 of those cases, I determined that Dr. Bischoff's actions in ordering escalating doses of intravenous Morphine (painkiller) and Ativan (anti-anxiety medication) were consistent with end-of-life care as practiced in almost all hospices in the world. In three cases, however, I determined that Dr. Bischoff departed from that pattern of care.

One of these cases involved an 85-year-old woman admitted with an acute myocardial infarcation (heart attack) associated with heart failure. She had underlying Alzheimer's disease and Type II diabetes. Dr. Bischoff ordered and administered two 100-microgram doses of Fentanyl, along with two 5-milligram doses of intravenous Versed, ten minutes apart. The patient was pronounced dead seven minutes after the second dose. The death of this patient resulted in criminal charges against Dr. Bischoff. The attending nurse's notes and testimony, as well as the family testimony regarding the physician's actions, suggested a brash disregard for the safety and standard of care for acutely ill individuals. The high doses of analgesic/sedative administered to the patient, together with its timing, strongly suggested that the intent of the treating physician was to hasten death. There was no evidence that consent was sought prior to the administration of medication. As in the Bischoff case, the physicians in this case are seeking opportunity to provide patients with doses of medication that most surely will hasten their death without any opportunity for review of intervention prior to death.

H. POSITION STATEMENT AGAINST PHYSICIAN ASSISTED SUICIDE

18. The following organizations have issued position statements against physician-assisted suicide: the American Psychiatric Association; the American College of Physicians; the American Medical Association; the American Academy of Geriatrics; the American Nursing Association; Canadian Palliative Care

Association; American Association of Hospice and Palliative Medicine; the Hospice and Palliative Nurse Association; American Pain Society; American Nurse's Society; in Great Britain, the National Council for Hospice and Palliative Care Services; in Australia, the Association for Hospice and Palliative Care.

19. Further your affiant sayeth naught.

T V Caughlan MD

DR. THOMAS V. CAUGHLAN

Subscribed and sworn to before me this 1 day of August, 2008.

MEGAN POOLE
NOTARY PUBLIC for the
State of Montana
Residing at
Kalispell, Montana
My Commission Expires
April 12, 2011

(SEAL)

Printed Name: Megan Poole
Residing at Kalispell, Montana.
My Commission expires: 4.12.11

Attitudes and Practices of U.S. Oncologists regarding Euthanasia and Physician-Assisted Suicide

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Background: The practices of euthanasia and physician-assisted suicide remain controversial.

Objective: To achieve better understanding of attitudes and practices regarding euthanasia and physician-assisted suicide in the context of end-of-life care.

Design: Cohort study.

Setting: United States.

Participants: 3299 oncologists who are members of the American Society of Clinical Oncology.

Measurements: Responses to survey questions on attitudes toward euthanasia and physician-assisted suicide for a terminally ill patient with prostate cancer who has unremitting pain, requests for and performance of euthanasia and physician-assisted suicide, and sociodemographic characteristics.

Results: Of U.S. oncologists surveyed, 22.5% supported the use of physician-assisted suicide for a terminally ill patient with unremitting pain and 6.5% supported euthanasia. Oncologists who were reluctant to increase the dose of intravenous morphine for terminally ill patients in excruciating pain (odds ratio [OR], 0.61 [95% CI, 0.48 to 0.77]) and had sufficient time to talk to dying patients about end-of-life care issues (OR, 0.79 [CI, 0.71 to 0.87]) were less likely to support euthanasia or physician-assisted suicide. During their career, 3.7% of surveyed oncologists had performed euthanasia and 10.8% had performed physician-assisted suicide. Oncologists who were reluctant to increase the morphine dose for patients in excruciating pain (OR, 0.58 [CI, 0.43 to 0.79]) and those who believed that they had received adequate training in end-of-life care (OR, 0.86 [CI, 0.79 to 0.95]) were less likely to have performed euthanasia or physician-assisted suicide. Oncologists who reported not being able to obtain all the care that a dying patient needed were more likely to have performed euthanasia ($P = 0.001$).

Conclusions: Requests for euthanasia and physician-assisted suicide are likely to decrease as training in end-of-life care improves and the ability of physicians to provide this care to their patients is enhanced.

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Euthanasia and physician-assisted suicide are highly controversial societal issues (1–3). In the past decade, there have been numerous surveys of physicians throughout the world on euthanasia and physician-assisted suicide (1, 4–14). Nevertheless, important deficiencies in information remain. First, most studies have been "snapshots"—surveys of attitudes or experiences at one point in time (15). Second, more than a fourfold variation exists in the reported rate of requests for and performance of euthanasia and physician-assisted suicide among U.S. physicians, making it difficult to draw definitive conclusions about physician practices (10, 11, 13, 14). Most important, almost all surveys of physicians have focused exclusively on euthanasia or physician-assisted suicide as isolated practices. None of the existing data provide insight into how these practices relate to optimal end-of-life care. To address some of these deficiencies, the American Society of Clinical Oncology (ASCO) surveyed all of its U.S. members about end-of-life care practices; we report part of the results of that survey.

Our focus on oncologists is appropriate because data from the Netherlands and Oregon indicate that more than 70% of patients using euthanasia or physician-assisted suicide have cancer (7, 16). In the United States, where patients with cancer tend to be treated by specialists, oncologists are likely to have to address the issue of euthanasia and physician-assisted suicide more often than other physicians (11, 14).

METHODS

Physician Identification

General eligibility requirements for the study were membership in ASCO in 1997, which included at least 85% of all oncologists in the United States, and being active in the management of "patients at the very end of life." Two groups were identified for participation; neither was compensated. First, all 8715 oncologists from the United States who were ASCO members were mailed a survey with a postage-paid return envelope. Physicians who did not return the survey after 4 weeks were mailed a

Table 1. **Sociodemographic Characteristics of Surveyed U.S. Oncologists**

Characteristic	All Oncologists (n = 3299)	Medical Oncologists (n = 2501)	Surgical Oncologists (n = 239)	Radiation Oncologists (n = 331)	Pediatric Oncologists (n = 228)
Mean age (range), y	47 (28–85)	47 (29–85)	49 (28–82)	48 (28–74)	45 (30–72)
Sex, %					
Male	80.6	81.8	85.4	77.9	66.5
Female	19.4	18.2	14.6	22.1	33.5
Religion, %					
Protestant	34.5	32.9	40.5	42.3	34.1
Catholic	26.6	26.6	31.5	25.3	23.5
Jewish	25.7	26.3	18.1	22.2	32.7
Other	13.2	14.2	9.9	10.2	9.7
Importance of religious belief, %					
Very important	34.0	34.2	38.3	35.0	26.3
Fairly important	33.0	32.2	36.2	36.5	33.3
Not important	33.0	33.7	25.5	28.5	40.4
Population of geographic setting, %					
<100 000 persons	12.1	13.4	5.1	12.8	4.4
100 000–500 000 persons	30.0	31.1	22.2	36.3	17.3
≥500 000 persons	57.9	55.6	72.6	50.9	78.3
Type of practice, %					
Academic	34.1	27.7	63.6	28.5	80.3
Oncology specialty group	34.2	37.6	7.9	46.4	6.6
Other	31.8	34.7	28.5	25.2	13.2
Time spent in patient care, %					
<50%	13.4	13.1	11.2	5.8	29.2
50%–89%	35.2	31.6	56.0	34.5	54.0
≥90%	51.5	55.3	32.8	58.7	16.8
Patients who died in the past 12 months, %					
<25	37.5	31.1	74.4	20.0	93.2
25–49	26.9	30.0	19.3	24.3	5.0
≥50	35.6	39.0	6.3	55.7	1.8

reminder letter with another copy of the survey. Of U.S. oncologists, 6642 were eligible; 2645 of these physicians completed the survey (response rate, 39.8%). Second, 1550 medical, surgical, radiation, and pediatric oncologists were randomly selected in a prospective manner to be contacted through personal telephone calls and additional mailings urging them to complete the survey. Of these physicians, 1273 were eligible and 655 completed the survey (response rate, 51.5%). The responses to all questions about euthanasia and physician-assisted suicide from these cohorts were statistically indistinguishable; therefore, responses from the two groups were combined, providing a total of 3299 responses.

Survey Development

In conjunction with the Center for Survey Research, a multidisciplinary task force created a survey instrument. After pretesting among oncologists, the instrument was finalized with 118 questions in eight areas. The precise wording of the questions that we analyzed is provided in the Appendix Table. Because the terms *euthanasia* and *physician-assisted suicide* can be both misunderstood and emotionally charged, previously reported descriptions of these activities were used in all questions (1, 13, 15).

Statistical Analysis

Comparisons among groups were performed by using the Pearson chi-square test of independence. Predictors of support for and performance of physician-assisted suicide and euthanasia were identified by using stepwise logistic regression analysis. To minimize type I errors and reduce the probability of identifying factors associated with differences that are not clinically meaningful, the selection criteria for entry into the model were set at an α level of 0.005.

Potential explanatory variables in all analyses were age, sex, religious affiliation, religiosity, importance of religious beliefs, death of a relative within the past 5 years, specialty, rural or urban practice, academic practice, amount of time in patient care, number of new patients in the past 6 months, and number of patients who died in the past year. Additional explanatory variables were barriers to providing

optimal care to terminally ill patients, time available to talk to terminally ill patients, perceptions of reimbursement levels, perceived difficulties in getting patients the care that they required, poor pain management decisions, proportion of terminally ill patients who are depressed, and personal responsibility for care of terminally ill patients.

RESULTS

Table 1 provides basic sociodemographic data on the 3299 U.S. oncologists who participated. Among all ASCO oncologists, 17.3% are female and 33.4% work in academic settings; these overall values are similar to those among survey respondents. More than 85% of respondents spent at least half their working time in direct patient care; 52% indicated that they devoted more than 90% of their time to clinical activities. Almost two thirds (61.4%) of respondents reported that 25 or more of their patients had died during the previous year.

Attitudes toward Euthanasia and Physician-Assisted Suicide

Of the 3299 U.S. oncologists who responded, 22.5% supported physician-assisted suicide for a terminally ill patient with prostate cancer who had unremitting pain despite optimal pain management, and 6.5% supported euthanasia (Table 2). Furthermore, 15.6% of the respondents indicated that they themselves would be willing to provide physician-assisted suicide and 2.0% would be willing to carry out euthanasia. These responses varied by oncologic subspecialty.

In multivariate analysis, four factors were associated with oncologists who were significantly less likely to support euthanasia and physician-assisted suicide: 1) reluctance to increase the intravenous morphine dose for a patient with metastatic breast cancer who was experiencing pain and requested relief (odds ratio [OR], 0.61 [CI, 0.48 to 0.77]); 2) reporting that they had sufficient time to talk to dying patients about end-of-life care issues (OR, 0.79 [CI, 0.71 to 0.87]); 3) viewing themselves as religious (OR, 0.68 [CI, 0.64 to 0.74]); and 4) being Catholic (OR, 0.57 [CI, 0.45 to 0.72]). Surgical oncologists were significantly more likely to support euthanasia or physician-assisted suicide (OR, 2.11 [CI, 1.52 to 2.92]). Attitudes toward euthanasia or physician-assisted suicide did not differ by age, sex, geographic region, year of graduation from medical school, number of new patients per year, number of patients who died in the past year, proportion of income from managed care, and clinical practice setting.

Practices regarding Euthanasia and Physician-Assisted Suicide

Of the 3299 responding oncologists, 62.9% had received requests for euthanasia or physician-assisted suicide during their career and 31.1% had received such requests during the previous 12 months (Table 2). The majority of requests were not fulfilled. Overall, 10.8% of responding oncologists had performed physician-assisted suicide in their career and 3.4% had done so in the preceding 12 months; 3.7% of oncologists reported performing euthanasia during their career while 0.8% had done so in the prior

Table 2. **Attitudes and Practices regarding Euthanasia and Physician-Assisted Suicide among Oncologic Specialties**

Practice	All Oncologists (n = 3299)	Medical Oncologists (n = 2501)	Surgical Oncologists (n = 239)	Radiation Oncologists (n = 331)	Pediatric Oncologists (n = 228)	P Value
	← % →					
Euthanasia						
Supports euthanasia for a patient in excruciating pain	6.5	5.3	12.7	6.8	13.7	0.001
Personally willing to provide euthanasia for a patient in excruciating pain	2.0	1.7	3.9	1.9	3.2	0.073
Has had requests during career	38.2	42.8	26.3	19.4	26.6	0.001
Has performed during career	3.7	3.4	3.1	2.2	9.5	0.001
Physician-assisted suicide						
Supports physician-assisted suicide for a patient in excruciating pain	22.5	20.5	32.2	26.5	30.9	0.001
Personally willing to provide physician-assisted suicide for a patient in excruciating pain	15.6	14.4	22.3	18.3	19.7	0.002
Has had requests during career	56.2	61.5	43.9	50.0	20.3	0.001
Has performed during career	10.8	10.8	11.8	13.0	4.5	0.012

12 months. Of the 10.8% of oncologists who had performed physician-assisted suicide, 37% had done so only once and 18% had done so five or more times. Of the oncologists who performed euthanasia, the majority (57%) had done so only once and 12% had done so five or more times. These practices varied significantly among oncologic subspecialties (Table 2).

Multivariate logistic regression analysis suggested that oncologists were significantly less likely to have performed euthanasia or physician-assisted suicide if they were unwilling to increase the dose of intravenous morphine for pain control in a patient with breast cancer who had excruciating pain (OR, 0.58 [CI, 0.43 to 0.79]) and if they reported that their training in end-of-life care was helpful (OR, 0.86 [CI, 0.79 to 0.95]). Conversely, oncologists who were less spiritual were significantly more likely to have performed euthanasia or physician-assisted suicide (OR, 1.77 [CI, 1.40 to 2.26]). Of note, 1.5% of oncologists who reported that they could get their dying patients all necessary care had performed euthanasia, whereas 6.2% of oncologists who reported that administrative, fiscal, and structural barriers allowed them to provide their dying patient with only some of the care they needed had performed euthanasia ($P < 0.001$).

Discussion

Our study of 3299 U.S. oncologists, the largest survey of physicians on the subject of euthanasia and physician-assisted suicide, provides four insights.

First, concern among oncologists about performing euthanasia and physician-assisted suicide may limit their willingness to prescribe opioids, thereby leading to inadequate pain management (8). Physicians who neither supported nor performed euthanasia and physician-assisted suicide were significantly less willing to increase the dose of intravenous opioids for patients with unremitting pain. This reticence probably reflects fear that increasing opioid dose increases the risks for respiratory depression and death and might be construed as a form of euthanasia. This view may be encouraged by proponents of euthanasia who have argued that there is no difference between increasing morphine for pain relief and euthanasia (2, 17, 18). The ASCO and others must educate physicians on the ethical and legal acceptability of increasing narcotics for pain control, even at the risk of respiratory depression and death (1, 3).

Second, the data suggest a relationship between the likelihood of performing euthanasia and physician-assisted suicide and the inability of physicians to obtain adequate end-of-life care for their patients. There is wide agreement that euthanasia and physician-assisted suicide should be reserved for circumstances in which optimal care cannot control pain and suffering. Some have worried that inadequate access to palliative care might make euthanasia and physician-assisted suicide attractive alternatives (19). Our data lend some support to this concern.

Third, physicians who reported receiving better training in end-of-life care seemed less likely to perform euthanasia or physician-assisted suicide (8). Physicians with better training in end-of-life care may feel more capable of providing optimal palliative care and less need to resort to euthanasia or physician-assisted suicide (8, 20).

Finally, the results suggest that among U.S. oncologists, support for euthanasia and physician-assisted suicide has decreased substantially. Between 1994 and 1998, oncologists' support for physician-assisted suicide in the prototypical case of a terminally ill patient with unremitting pain declined by half, from 45.5% in 1994 to 22.5% in this study. Similarly, support for euthanasia has declined by almost three quarters, from 22.7% to 6.5% (13, 15). This decline may reflect expanding knowledge about how to facilitate a "good death," making euthanasia and physician-assisted suicide no longer seem necessary or desirable (20).

Our study has several limitations. The low overall response rate of 39.8% raises the possibility of significant bias in the results. For instance, if all of the nonrespondents opposed euthanasia and physician-assisted suicide, the support would be only 2.6% for euthanasia and 9.0% for physician-assisted suicide and only 25.0% of physicians would have received requests for either intervention. Of note, there were no differences in the views of the oncologists targeted for intensive follow-up where the response rate was over 50%. The sociodemographic characteristics of respondents were similar to those of all ASCO members. In addition, the questions on euthanasia and physician-assisted suicide were set within a larger survey on end-of-life care, minimizing the possibility that nonrespondents differed on their views related to euthanasia or physician-assisted suicide. Our data reflect the views of oncologists who were members of ASCO and thus may not be generalizable to oncologists who do not belong to ASCO and to other types of physicians (9, 14). Finally, we used restrictive selection criteria for entry into the model; conse-

Appendix Table. **Survey Questions***

Subject of Question	Survey	Wording of Question
Attitudes toward euthanasia and physician-assisted suicide	1998 ASCO survey of 3299 oncologists	A 63-year-old man develops metastatic prostate cancer that invades the bones and causes excruciating pain. His disease is refractory to hormonal therapy. The appropriate use of morphine, radiation therapy, nerve blocks, and other palliative measures are failing to control the pain completely.
	1994 survey of a random sample of 355 U.S. oncologists (13)	A patient develops metastatic cancer which invades the bones resulting in excruciating pain. Current levels of morphine, nerve blocks, and other treatments are failing to completely control the pain. In this case, is it all right, upon request from the patient, to intentionally prescribe drugs so the patient could end his or her life by overdose?
Pain management	1998 ASCO survey	A long-term patient of yours with metastatic breast cancer is hospitalized for pain control. Her pain is not well controlled despite 75 mg per hour of parenteral morphine. You have tried fentanyl as well as ketamine, without noticeable improvement in pain control. You are concerned that if you increase the morphine dose to control additional pain, she might have sufficient respiratory depression to die. She states that the pain is excruciating and demands relief.
Barriers to optimal end-of-life care	1998 ASCO survey	When you think objectively about ALL the administrative, fiscal, and structural barriers to delivering quality care to dying patients, how effective would you say you are at getting your dying patients the care they need?

* ASCO = American Society of Clinical Oncology.

quently, the odds ratios may be influenced by unmeasured confounders.

Overall, our results emphasize the need to educate physicians about optimal pain and palliative care practices throughout their formal training and as part of their continuing medical education. Physicians who are better informed about end-of-life issues feel less need to use euthanasia and physician-assisted suicide.

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And yet uncle in his old age was probably not unhappy. He had one hobby of never-failing interest, and that was his diseases. He suffered, by his own account, from every disease in the medical dictionary, and was never weary of talking about them. Indeed, it seemed to Gordon that none of the people in his uncle's boarding-house—he had been there occasionally—ever did talk about anything except their diseases. All over the darkish drawing-room, ageing, discoloured people sat about in couples, discussing symptoms. Their conversation was like the dripping of stalactite to stalagmite. Drip, drip. "How is your lumbago?" says stalactite to stalagmite. "I find my Kruschen Salts are doing me good," says stalagmite to stalactite. Drip, drip, drip.

George Orwell
Keep the Aspidistra Flying
San Diego; Harcourt Brace; 1936:59

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Submissions from readers are welcomed. If the quotation is published, the sender's name will be acknowledged. Please include a complete citation (along with page number on which the quotation was found), as done for any reference.–*The Editor*

The Rule of Double Effect

Clearing Up the Double Talk

RECENTLY, the rule of double effect, which has a long history in ethics, especially medical ethics, has come under serious criticism in the medical literature.[1,2] Because of its immense practical importance in the care of dying patients, any attack on this rule must be taken seriously. In this article, therefore, we present a systematic rejoinder to what we take to be serious misunderstandings of the nature and use of this rule.

A clear understanding of the proper use of the rule of double effect is essential if health care professionals are to maintain their opposition to euthanasia and assisted suicide and yet provide adequate pain relief to dying patients. Many Americans, including health care professionals, are fearful of unwittingly participating in euthanasia if a patient's death is hastened, however unintentionally, as a side effect of attempts to relieve pain and suffering. For such individuals, the rule of double effect provides moral reassurance and thus encourages optimal care of the dying. This is why the rule figures prominently in the opinions of the American Medical Association.[3,4]

NATURE AND CONTENT OF THE RULE OF DOUBLE EFFECT

Although variously formulated, the traditional rule of double effect specifies that an action with 2 possible effects, one good and one bad, is morally permitted if the action: (1) is not in itself immoral, (2) is undertaken only with the intention of achieving the possible good effect, without intending the possible bad effect even though it may be foreseen, (3) does not bring about the possible good effect by means of the possible bad effect, and (4) is undertaken for a proportionately grave reason.[4-8] This moral rule has wide application, but has played a particularly important role in the care of the dying, allowing those who are morally opposed to euthanasia and assisted suicide to provide adequate pain relief without violating traditional medical morality or their consciences.

Treating dying patients in pain with appropriate doses of morphine is generally done in a manner that satisfies the criteria for double effect. The use of morphine (1) is not in itself immoral; (2) it is undertaken only with the intention of relieving pain, not of causing death through respiratory depression; (3) morphine does not relieve pain only if it first kills the patient; and (4) the relief of pain is a proportionately grave reason for accepting the risk of hastening death. Some physicians, who are opposed to euthanasia and assisted suicide, might avoid giving opioid analgesics to dying patients out of fear of hastening death and committing euthanasia. According to the rule of double effect, however, the appropriate and compassionate use of morphine is morally permissible even for those who are morally opposed to euthanasia and assisted suicide. This rule allows physicians opposed to euthanasia and assisted suicide to treat pain adequately in these situations with a clear conscience.

THE UNDERLYING ISSUE

If one believes that euthanasia and assisted suicide are sometimes morally permissible, then the rule of double effect has no role to play in the care of dying patients. If it is not wrong to intend that a patient die by way of one's clinical act, then there is no need to bother with the rule of double effect. However, millions of American health care professionals and patients are morally opposed to euthanasia and assisted suicide. For such individuals, we argue, the rule of double effect is perfectly coherent and of great clinical importance.

LOGICAL INCONSISTENCIES WITH POTENTIALLY DELETERIOUS EFFECTS ON PATIENT CARE

Undermining the rule of double effect has the potential to affect the care of the dying adversely, since most physicians report that they are personally reluctant to perform euthanasia or assisted suicide even if it is legalized.[9-12] Some of the critics of double effect seem to want things both ways. They acknowledge that "the rule of double effect may be useful as a way of justifying adequate pain relief and other palliative measures for dying patients."[1] But at the same time, they argue that this moral rule is not credible.

The rule of double effect is either valid or invalid. It cannot be both. If the rule of double effect is, in fact, logically and morally valid, then the most helpful policy for patients would be to educate physicians about its proper application. Those who already approve of euthanasia and assisted suicide cannot logically be opposed to giving drugs in a manner consistent with the rule of double effect. They might, in addition, want to give lethal doses or administer other lethal treatments, but they cannot be opposed to relieving pain. By educating phy-

sicians about the rule of double effect, more patients will receive adequate pain control from physicians who are opposed to euthanasia and assisted suicide and might otherwise be reluctant to provide such treatment.

On the other hand, if one believes that the rule of double effect is somehow incoherent, how can one argue that physicians who are opposed to euthanasia or assisted suicide should use it in the care of patients? If this rule really makes no sense, then it follows logically that those physicians who are conscientiously opposed to euthanasia and assisted suicide should not prescribe opioid analgesics for the dying. They would have no choice but to refrain from using these drugs, because without the rule of double effect, they would be forced to consider all actions that risk hastening the death of the patient to be euthanasia. And this would be a horrifying consequence for patients.

If, however, as we argue later, the rule of double effect is valid, then those opposed to euthanasia and assisted suicide can feel morally reassured when using appropriate doses of opioid analgesics in the care of dying patients.

MISCONSTRUING DOUBLE EFFECT

Critics misconstrue this moral rule when they suggest that it is simply a rule that enables one to decide whether one potentially harmful action is preferable to another.[1,2] This is not true. The rule of double effect is not simply an instrument of consequentialist reasoning, ie, determining the moral status of an action on the basis of net utility. One does not begin double effect reasoning by first examining the consequences of a proposed action and then deciding whether the net consequences are such that there might be a good reason to override some prima facie prohibition against the action. Rather, one sets out to do a morally good action, taking full account of the foreseeable consequences. If the action conforms to the conditions of the rule of double effect, one may proceed even under circumstances in which that action might have dangerous side effects. This is a different idea from the notion that one simply picks the lesser of 2 evils.

DOUBLE EFFECT AND ASSISTED SUICIDE

The critics have created a straw man when they suggest that if the rule of double effect were true, then physician-assisted suicide should be permitted by its adherents.[1] They provide no citation of such an argument by anyone who subscribes to the rule of double effect.

They also make a category mistake by applying this rule to the situation of assisted suicide. The rule of double effect is only 1 moral rule among many. It is only designed to cover certain kinds of actions, while other rules cover other kinds of actions. According to the standard account, the rule does not apply to situations in which the effects under consideration involve the intentions of intervening agents. The rule of double effect can only be applied to situations in which the possible good and bad effects follow directly on an agent's actions.[13] For example, Quill et al[1] claim that the physician writing a lethal prescription might only intend to "reassure the patient by providing a potential escape from suffering that the physician hopes or expects will not be used." Assisted suicide, however, requires that a patient form an intention to bring about the bad effect that the physician is allegedly claiming to intend to avoid, ie, suicide. The suicidal death of the patient does not follow directly from the writing of the prescription, but from the patient's intentional use of that prescription. Therefore, the rule of double effect does not apply.

Presuming, as proponents of the rule of double effect do, that euthanasia and suicide are morally wrong, the moral question for the physician in cases of assisted suicide is whether the physician's assistance in the suicide is morally acceptable. Therefore, the proper moral category for such physicians is not double effect but cooperation (ie, whether the physician is an accomplice and therefore morally culpable).[14,15] The patient is asking for the physician's assistance in providing "a possible way out." The physician writes the lethal prescription knowing that the patient has already formed a provisional commitment to the possibility of taking these drugs. Without the physician's cooperation, this possible intent could not be carried out in the way the patient intends it. If the physician is morally opposed to euthanasia and suicide, the physician has thus cooperated in the death if the patient goes on to commit suicide.

Double effect would apply here only if the patient expressed no intention either to commit suicide or to have a lethal dose available "just in case." A physician might write a prescription for an opioid analgesic to treat pain, and the patient might surreptitiously stockpile the pills and take them in a suicide attempt. This is always a possibility with any drug that is used clinically, whether it is an opioid analgesic or digitalis. If one recognizes that this is a possibility, but has no indication that this is the patient's intention, one is not an accomplice in the suicide. However, if the patient clearly signals such a possible intention, one is an accomplice if the patient commits suicide.

To illustrate this, consider someone who is asked to give a stick of dynamite to a distraught employee who has recently been fired and is expressing a vague wish to blow up his place of former employment. It is hardly plausible in such a situation to invoke the rule of double effect and say that one would only be intending to ease the employee's anxiety by giving him the dynamite. It is true, he might or might not blow up the building. But if the employee does blow up the building, one is a moral accomplice because one has supplied the means, knowing of the former employee's possible intention. The same is true of assisted suicide. If one knowingly supplies the means, one is an accomplice.

Furthermore, suppose one were to try to stretch the rule of double effect to cover the situation of assisted suicide. Even so, the rule of double effect would prohibit this action, provided one were morally opposed to suicide in the first place. To

try to make assisted suicide fit under the rule of double effect, one would need to make the claim that one was giving pills without intending the patient's possible suicide. However, the third condition of the rule of double effect requires that the possible bad effect not be the means of producing the possible good effect. In this case, what one would be claiming not to intend, the possibility that the patient might actually take the overdose and die, is, in fact, the very means by which the patient is reassured. Therefore, the rule of double effect would not justify assisted suicide.

DOUBLE TALK ABOUT TERMINAL SEDATION

Terminal sedation, in which dying patients may be given doses of drugs to treat specific symptoms, but subsequently lapse into coma and die, is an extraordinarily rare event in the hands of experts in hospice and palliative care.[15] Good palliative care physicians aim at maximizing symptom control and function at the same time. Under the rule of double effect, however, they sometimes can accept sedation to the point of unconsciousness as a side effect of a specific treatment aimed at a specific symptom. That is, they accept sedation that may happen to be terminal. They do not sedate as part of a plan to terminate. However, some authors[2,16] are now erroneously suggesting an extension of the meaning and scope of this practice to include the practice of certain forms of euthanasia under the legal cover of what has traditionally been permitted as double effect.

To use the rule of double effect properly, one must be careful to specify the effects one is aiming at, and be reasonably sure that the proposed intervention can possibly achieve this effect. "Relief of suffering" is far too broad an effect to have practical clinical meaning. Good clinicians use specific drugs to treat specific symptoms, and under the rule of double effect, can, at times, accept the possibility of loss of patient consciousness as a side effect of treating these symptoms. For example, consider a patient who is days away from death, already beginning to experience diminished consciousness as a consequence of the natural progression of her disease, in extreme pain, and asking for relief. Under the rule of double effect, it is perfectly appropriate to treat the patient's pain with an opioid analgesic, recognizing that the patient may subsequently lose consciousness as an unintended side effect, consequently not eat, and die sooner.

This is a different case from a patient with early Alzheimer disease who is suffering because of fear of what the future might bring, asking for help in hastening death. In sedating such a patient to the point of unconsciousness, the intention is to hasten death. This would therefore not be permitted under the rule of double effect and ought not be permitted on that basis under law so long as euthanasia remains illegal.

Or consider an elderly patient without pain but with severely limited mobility because of inoperable degenerative arthritis, who may be experiencing a kind of existential angst, or what the Dutch euthanists call "tiredness of life."[17] The only way that a barbiturate could relieve the symptoms of tiredness of life would be by causing the unconsciousness and death of the patient. But this violates the rule of double effect, since the allegedly unintended possible bad effect (unconsciousness and death) is the means of achieving the possible good effect (relief from tiredness of life). Therefore, this sort of "terminal sedation" is simply a form of active euthanasia and would not be permitted under double effect.

However, consider the sort of case in which a patient with metastatic cancer has been treated for many months with opioid analgesics and has developed myoclonus as a side effect of these drugs. Suppose the patient has been treated with benzodiazepines for the myoclonus, but the myoclonus persists. Suppose the patient has also been treated with adjuvant tricyclic antidepressants, a nerve block, and biofeedback and the pain is still not relieved. Under such extraordinary circumstances, one could consider the use of barbiturates as a way to suppress the myoclonus and bring the patient relief from anxiety that may be exacerbating the pain. As long as these were one's intentions, and one were only to use as much barbiturate as was necessary to suppress these symptoms, having established with the patient that unconsciousness might result as an unintended side effect, one could proceed with such measures under the rule of double effect. This should be a measure of last resort, but one that might, in extremely rare circumstances and in careful hands, be necessary. This is the sort of case of terminal sedation that has traditionally been permitted but rarely performed under the rule of double effect.

Thus, some kinds of terminal sedation are permitted under the rule of double effect, and some are not. In those kinds that are permitted, sedation is an unintended but foreseen side effect. In those kinds that are not permitted, the intended purpose of the sedation is the termination of the patient's symptoms by means of the termination of the patient's existence.

WITHDRAWING LIFE-SUSTAINING TREATMENT IS NOT AN APPLICATION OF DOUBLE EFFECT

A further mistake is the suggestion that the withdrawal of life-sustaining treatments is traditionally justified by the rule of double effect.[1] Once again, this is a misapplication of the rule of double effect, albeit one that has been perpetuated in the literature.[18] Once more, it pays to understand that the rule of double effect is but one rule among many. Traditionally, the refusal of life-sustaining treatments has been justified under the rule that one is permitted to withdraw life-sustaining treatments in circumstances in which their use is considered "extraordinary" or "disproportionate."[19,20] Like the rule of double effect, the ordinary vs extraordinary distinction requires a proportionately grave reason, but it is a distinct moral rule.[21] Morally cautious patients or health care professionals who do not support euthanasia or assisted suicide have been permitted to withhold and withdraw life-sustaining treatments that are futile or dispropor-

tionately burdensome under Roman Catholic moral theology since at least the 1500s,[19] years before the rule of double effect had ever been explicitly formulated in the moral literature.[22] Under this rule, one is permitted to refuse life-sustaining treatments that are of no benefit or are disproportionately burdensome. It is a rule for refusing treatment, not a rule to guide active treatment.

There is no need to invoke the rule of double effect in withdrawing life-sustaining treatments. One need only invoke the dictum that there is no moral obligation to use futile or excessively burdensome treatments.

THE DISAMBIGUATION OF CLINICAL INTENTIONS

Quill[23] has argued forcefully that clinical intentions are inherently ambiguous, and cannot be used to evaluate the morality of clinical actions. This is an extremely problematic position, reiterated in the recent attacks on the rule of double effect.[1,2] Common sense and the law place important weight on intentions in evaluating the morality of human actions, and properly so. Intentions are vital to our understanding of virtuous actions, and in explicating what it means sincerely to act with respect for another's dignity.[5] Careful distinctions are also drawn, for instance, between manslaughter, murder in the first degree, and so forth, purely on the basis of judgments about human intentions. What is done with "malice aforethought" is deemed far more troubling morally than what is done unintentionally.

The morality of everyday clinical practice depends heavily on the concept of intention, and clinicians have an unarticulated, intuitive grasp of the rule of double effect in almost all their therapeutic interventions. This is because the whole notion of a side effect is totally dependent on the rule of double effect and the concept of intention.[24] For instance, when physicians treat streptococcal pharyngitis with penicillin, they foresee the possibility that the patient might develop an anaphylactic reaction and die. But they only intend to kill the bacteria, not to kill the patient. The death of the patient is not the cause of the death of the bacteria, and the rarity of anaphylaxis and the harm of not treating makes the risk proportionate and worth taking. Even so simple an action as prescribing penicillin already presumes something about intention and is actually an application of the rule of double effect. This is the case with any powerful drug.

At times, of course, it can be difficult to judge human intentions. But as Samuel Johnson once said, "The fact of twilight does not mean there is no difference between night and day."[25] If a clinician gives 10 mg of morphine intravenously over 5 minutes to a nonopioid-tolerant patient with significant pain, this action is consistent with an intention to relieve pain and not to kill the patient. But if a clinician were to give 5000 mg of morphine intravenously over 15 seconds to a nonopioid-tolerant patient to relieve the patient's "suffering," knowledgeable clinicians would have no doubt about that clinician's intentions. This difference is as clear as the difference between night and day.[26]

Contrary to the contentions of the critics, a great deal of contemporary work in the philosophy of action shows how intentions differ from beliefs and desires and supports the importance of distinguishing between the foreseen and the intended.[27-31] Space requirements prohibit a full discussion of this matter herein. The application of this intention theory to bioethical discourse is only just beginning.[32]

LAW DOES NOT SETTLE THE MORAL QUESTION

Legal arguments do not settle moral questions. It is a truism to state that all that is legal is not moral, and that all that is moral is not necessarily legal. Therefore, legal opinions about assisted suicide or euthanasia really only have moral weight to the extent that they are morally persuasive. The legal arguments of the critics do not address the moral issues.

The recent US Supreme Court decision regarding assisted suicide invoked double effect reasoning.[33,34] An interesting legal argument has been offered that this might lay the groundwork for establishing a constitutional right to adequate pain relief for the dying.[35] But the justices made no moral arguments for accepting the rule of double effect, and the recent discussions of the court's decision in the medical literature do not attempt to find such a moral argument. Furthermore, the fact that critics of prohibitions on assisted suicide and euthanasia point out that physicians accused of assisted suicide are often acquitted is not an argument against the logical and moral validity of the rule of double effect. Judges and juries and legislators may make decisions within the bounds of law and yet make morally incorrect judgments.

RELIGION, MORALITY, AND SOCIETY

Quill et al[1] suggest that among the "shortcomings" of the rule of double effect as a guideline for medical morality in a pluralistic society is the fact that "the rule originated in the context of a particular religious tradition." This is a very odd position. Should the commonly held position that stealing is morally wrong be rejected simply because it can be found (Exodus 20:15) in the commandments of a particular religious tradition? The religious origins of a moral principle or rule should not preclude its discussion in civil society. Nor should the congruence between a moral argument's conclusions and the teachings of a religion undermine the validity of the argument. An exhortation to exclude such rules and principles in the name of tolerance seems itself highly intolerant.

There is nothing about the rule of double effect that is inherently religious. The fact that it was developed by theologians does not vitiate the fact that it might be morally true. Nothing about the rule presumes any knowledge of scripture or the teachings of any religion. All that is required is a belief that certain actions are absolutely morally prohibited, or, more controversially, at least a belief that consequences are not the sole determinants of the morality of an action.[36] Many clinicians be-

lieve, for a variety of reasons, some religious and some not, that euthanasia and assisted suicide are always morally wrong. Such clinicians need a rule of double effect.

A logically rigorous argument against the rule of double effect would deal with the rule on its own terms. To raise the question of the origin of the rule as a reason to discredit it is a form of the logical fallacy of the ad hominem argument—to claim to discredit an argument because of who states it.

Moreover, while it has had its origins in a particular religious tradition, the rule of double effect has been widely discussed and defended in the philosophical literature apart from its origins.[36-39] Its applications are far wider than medicine. For instance, it is the basis of the distinction between terror bombing and strategic bombing in just-war theory.[7,25,27,40] The argument that it should be rejected out of hand simply because it originated with a particular religious tradition is completely unwarranted.

PATIENT AUTONOMY: A MORAL ABSOLUTE?

While we agree with the critics that autonomy holds an important place in Western medical ethics and law, we fail to see how this justifies the conclusion that the patient's autonomous preference for death is more fundamental than whether the physician intends to cause death.[1,2] These authors[36] simply assume that there can be no moral absolutes, such as a prohibition on the direct killing of patients by physicians. This begs the central moral question in the debate over assisted suicide. We, on the other hand, are making a more limited claim, and making our assumptions explicit. We are only arguing that if one believes, for whatever reasons, that euthanasia and assisted suicide are always morally wrong, even if requested by a patient, then the rule of double effect can be used sensibly and coherently to examine important cases in the practice of medicine, particularly the care of the dying.

The US Supreme Court has recently decided that there is no constitutionally guaranteed legal right to actions that cause death,[33,34] but the *moral* question remains the central one that must be debated. Certainly, no one has yet seriously argued that physicians have a moral obligation to provide assistance with suicide or euthanasia on demand even if they conscientiously object to these practices. This would violate the autonomy of the clinicians.

While space considerations preclude a full discussion, multiple arguments about the nature of the practice of medicine,[41] the value of preserving life,[42] and concerns about the slippery slope consequences of legalizing euthanasia and assisted suicide[43] have been made to argue against allowing patients the autonomy to demand these practices. Others[44] have argued that assisted suicide can never itself truly be autonomous. The central moral issue in the debate about euthanasia and assisted suicide is whether these are good arguments.

As the critics point out, the rule of double effect is only morally important if euthanasia and assisted suicide are considered immoral. An attack on the rule of double effect therefore only makes sense when viewed as part of a strategy to promote the legalization of physician-assisted killing by undermining physicians' confidence in a commonly accepted moral rule that depends on the presumption that killing patients is morally wrong. But if the arguments against double effect are themselves inadequate, mistaken, or confused, then one must face squarely the real question at stake—whether patient autonomy is such a moral absolute that countervailing considerations will not stand.

CONCLUSIONS

The rule of double effect has traditionally played an important role in medical ethics. It is the philosophical underpinning for the critically important concept of a side effect. The rule of double effect needs to be accurately understood and carefully specified, so that clinicians opposed to euthanasia and assisted suicide can understand that they might conscientiously use potent drugs to treat terminally ill patients under circumstances in which hastening the death of the patient can be considered a morally permissible side effect. Recent attacks on this moral rule therefore do the medicomoral community a disservice, since these attacks have been fraught with misinterpretations, misapplications, hasty generalizations, and logical fallacies.

It goes without saying that those who accept the moral permissibility of euthanasia and assisted suicide have no need for a rule of double effect. For them, hastening the patient's death is not a "bad" effect to be avoided. But for most physicians, who report that they personally would not perform euthanasia, the rule is important. It allows them to treat specific symptoms of dying patients even at the risk of hastening death while preserving their conscientious objection to euthanasia. The importance of the rule of double effect needs to be underscored at a time when the public is clamoring for improved care of the dying and the US Supreme Court has declared that there is no constitutional right to assisted suicide. Recent attacks on this rule are therefore not only to be faulted as ill-conceived, but also as ill-timed. For the benefit of patients, we hope that this article addresses these objections to the rule of double effect and that clinicians will understand and apply that rule properly.

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Special Reports from the Netherlands

EUTHANASIA, PHYSICIAN-ASSISTED SUICIDE, AND OTHER MEDICAL PRACTICES INVOLVING THE END OF LIFE IN THE NETHERLANDS, 1990–1995

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ABSTRACT

Background In 1991 a new procedure for reporting physician-assisted deaths was introduced in the Netherlands that led to a tripling in the number of reported cases. In 1995, as part of an evaluation of this procedure, a nationwide study of euthanasia and other medical practices concerning the end of life was begun that was identical to a study conducted in 1990.

Methods We conducted two studies, the first involving interviews with 405 physicians (general practitioners, nursing home physicians, and clinical specialists) and the second involving questionnaires mailed to the physicians attending 6060 deaths that were identified from death certificates. The response rates were 89 percent and 77 percent, respectively.

Results Among the deaths studied, 2.3 percent of those in the interview study and 2.4 percent of those in the death-certificate study were estimated to have resulted from euthanasia, and 0.4 percent and 0.2 percent, respectively, resulted from physician-assisted suicide. In 0.7 percent of cases, life was ended without the explicit, concurrent request of the patient. Pain and symptoms were alleviated with doses of opioids that may have shortened life in 14.7 to 19.1 percent of cases, and decisions to withhold or withdraw life-prolonging treatment were made in 20.2 percent. Euthanasia seems to have increased in incidence since 1990, and the ending of life without the patient's explicit request seems to have decreased slightly. For each type of medical decision except those in which life-prolonging treatment was withheld or withdrawn, cancer was the most frequently reported diagnosis.

Conclusions Since the notification procedure was introduced, end-of-life decision making in the Netherlands has changed only slightly, in an anticipated direction. Close monitoring of such decisions is possible, and we found no signs of an unacceptable increase in the number of decisions or of less careful decision making. (N Engl J Med 1996;335:1699-705.)

IN the Netherlands, euthanasia and physician-assisted suicide have been practiced with increasing openness, although technically they remain illegal. In 1990–1991 a nationwide study of euthanasia and other medical practices related to the ending of life was conducted, commissioned by a governmental committee chaired by Professor Jan Remmelink, the attorney general of the Dutch Supreme Court.[1,2] The study attracted a great deal of attention, partly because it gave the first complete overview of medical decisions concerning the end of life in a single country.

At about the same time, a new procedure for reporting cases of euthanasia and physician-assisted suicide was introduced.[3,4] Probably as a result, the number of reported cases of euthanasia increased, from 486 in 1990 to 1466 in 1995. In 1995–1996 we conducted a second nationwide study, almost identical to the first, in an evaluation of the new procedure that was commissioned by the ministers of health and justice. The purpose of the 1995 study was to make reliable estimates of the incidence of euthanasia and other medical practices pertaining to the end of life; to describe the patients, physicians, and circumstances involved; and to evaluate changes in these practices between 1990 and 1995. We conducted two separate studies, one based on interviews with a stratified sample of 405 physicians and the other based on responses to mailed questionnaires about a sample of 6060 deaths.

METHODS

The Interview Study

We interviewed a stratified random sample of 405 physicians that included 124 general practitioners, 74 nursing home physicians, and 207 physicians in five specialties (cardiology, surgery, internal medicine, pulmonology, and neurology). Such physicians attend 87 percent of all deaths in the Netherlands occurring in hospitals (where about 40 percent of deaths occur) and almost all

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deaths outside the hospital. To be selected for the study, the physicians interviewed had to have been practicing in their registered specialties since January 1, 1994, and to have worked at the same institution since then. So that the desired number of 410 interviews could be conducted, 559 physicians were sampled. Eighty-three did not meet the criteria for selection, and 21 others had chronic illnesses or could not be located. Fifty physicians (11 percent of those who met the selection criteria) declined to take part in the study.

The interviews were conducted from November 1995 through February 1996 by about 30 experienced physicians. All the interviewers were trained intensively for the study. The questionnaire used to guide the interview ran to about 120 pages, and the interviews lasted 2½ hours on average.

To extrapolate our findings to all deaths in the Netherlands, we calculated weights based on the proportions of physicians of the various types who were represented in the sample. Our estimates of incidence were corrected for the 13 percent of in-hospital deaths that were attended by clinicians in specialties other than the five sampled, on the assumption that among these remaining deaths the various types of medical decisions related to the end of life were as frequent as in the deaths studied.

The Death-Certificate Study

The causes of death for all inhabitants of the Netherlands are reported to Statistics Netherlands. Patients are not mentioned by name on the cause-of-death forms, but the names of the reporting physicians are given. The medical officer in charge of the cause-of-death statistics selected a stratified sample containing the deaths occurring from August 1 through December 1, 1995. The forms for all 43,000 deaths in this period were examined by two physicians and assigned to one of five strata, denoted 0 through 4. When the cause of death was one in which it was clear that no medical decision about the end of life could have been made (for example, a car accident resulting in an instant death), the death was assigned to stratum 0. These cases were retained in the sample, but no questionnaires were sent to the physicians, because no further information was needed in order to determine that no medical decisions about the end of life had been involved. When the likelihood was deemed high that there had been a medical decision that may have hastened death, the death was assigned to stratum 4.

The final sample contained half the cases in stratum 4, 25 percent of the cases in stratum 3, 12.5 percent of those in stratum 2, and 8.3 percent of those in strata 1 and 0 each. A procedure was devised to ensure that the physicians and the deceased persons would remain completely anonymous. All Dutch physicians received a letter explaining the purpose of the study and how anonymity would be guaranteed. Of the 6060 questionnaires mailed, 77 percent were returned. Nearly all were completed carefully, and many contained information in addition to that requested.

The study questionnaire contained 24 items. In classifying the responses in terms of the types of end-of-life medical decisions made, we studied how the respondents answered four questions. What did the physician do (or not do)? What was his or her intention in doing so? Was the physician's decision made at the request of the patient or after discussion with the patient? And was the patient competent (that is, able to assess the situation and make a decision about it adequately)?

Euthanasia was defined as the administration of drugs with the explicit intention of ending the patient's life, at the patient's explicit request. Physician-assisted suicide was defined as the prescription or supplying of drugs with the explicit intention of enabling the patient to end his or her own life (the administration of lethal drugs by both the patient and the physician was considered to be euthanasia). The ending of life without an explicit request was defined as the administration of drugs with the explicit intention of ending the patient's life without a concurrent, explicit request by the patient. The alleviation of pain and symptoms with opioids was defined as the administration of doses large enough that there was a probable life-shortening effect. A decision not to treat was defined as the withholding or withdrawal of potentially life-prolonging treatment.

In both studies the questionnaires used were almost identical to those used in the 1990 study. The study designs were identical, although the prospective part of the earlier study was not repeated. In the mailed questionnaires we avoided the terms euthanasia and physician-assisted suicide, because their connotations are too varied. Instead, we used wording that more closely described actual medical practice, permitting us to classify the answers in the categories defined here. In the interviews, terms such as euthanasia and physician-assisted suicide were used, since the interviewer would be able to discuss meanings and obtain more detailed information about the cases described. Thus, the two studies were designed to generate complementary information, with the interviews producing more detailed background information and the death-certificate study providing a strong quantitative framework. Ninety-five percent confidence intervals were calculated that took into account the stratification procedure and the probability of the various types of decisions in each stratum.[5]

RESULTS

Incidence Estimates

The two studies yielded similar estimates of incidence with regard to most of the practices studied (Table 1). There were 34,500 requests for euthanasia at a later time in the course of disease, a 37 percent increase from the 1990 number. There were 9700 explicit requests for euthanasia or physician-assisted suicide at a particular time, a 9 percent increase from 1990. In the interview study 2.3 percent of all deaths resulted from euthanasia, as compared with 2.4 percent in the death-certificate study. In 1990 the rates were 1.9 and 1.7 percent, respectively. Assisted suicide occurred in 0.4 percent of deaths in the interview study and 0.2 percent of deaths in the death-certificate study, as compared with 0.3 and 0.2 percent, respectively, in 1990. In both 1995 studies 0.7 percent of deaths involved ending the patient's life without the patient's explicit, concurrent request. In 1990, 0.8 percent of deaths in the death-certificate study occurred in this way.

The estimated incidence of the alleviation of pain and symptoms with a possible shortening of life differed in the two 1995 studies, probably because in the interviews the question was phrased somewhat more strictly. The death-certificate study offered the best basis for comparison with the earlier study, and it showed no significant change since then. Decisions to forgo treatment occurred in 20.2 percent of cases, as compared with 17.9 percent in 1990. Thus, for more than 42 percent of all deaths in the Netherlands, medical decisions concerning the end of life seem to have been made. In about 2.0 percent of all deaths — the same figure that was reported in 1990 — the physicians' intentions were either ambiguous or inconsistent with their practices: in 1.4 percent of cases, the respondents said that they had alleviated pain and symptoms with opioids, but with the explicit intention of ending the patient's life; and in

TABLE 1. ESTIMATED INCIDENCE OF MEDICAL DECISIONS RELATED TO THE END OF LIFE.*

VARIABLE	INTERVIEW STUDY				DEATH-CERTIFICATE STUDY	
	1995		1990		1995	1990
No. of requests for euthanasia or assisted suicide later in disease	34,500	(31,800–37,100)	25,100	(23,400–27,000)	ND	ND
No. of explicit requests for euthanasia or assisted suicide at a particular time	9700	(8800–10,600)	8900	(8200–9700)	ND	ND
End-of-life practices — % of deaths†						
Euthanasia	2.3 (1.9–2.7)		1.9 (1.6–2.2)		2.4 (2.1–2.6)	1.7 (1.4–2.1)
Physician-assisted suicide	0.4 (0.2–0.5)		0.3 (0.2–0.4)		0.2 (0.1–0.3)	0.2 (0.1–0.3)
Ending of life without patient's explicit request	0.7 (0.5–0.8)		ND		0.7 (0.5–0.9)	0.8 (0.6–1.1)
Opioids in large doses	14.7 (13.5–15.7)		16.3 (15.3–17.4)		19.1 (18.1–20.1)	18.8 (17.9–19.9)
Decision to forgo treatment	ND		ND		20.2 (19.1–21.3)	17.9 (17.0–18.9)
All of these	—		—		42.6 (41.3–43.9)	39.4 (38.1–40.7)

*Numbers in parentheses are 95 percent confidence intervals. ND denotes not determined, because the study data did not permit these estimates to be calculated.

†Percentages are based on the total number of deaths in the Netherlands: 135,546 in 1995 and 128,786 in 1990.

0.6 percent, they said that they had ended the patient's life without the patient's explicit request but had only partly intended to do so.

Euthanasia and Physician-Assisted Suicide

Of the physicians interviewed, 88 percent said they had received at least one request for euthanasia or physician-assisted suicide at a later time in the course of disease, whereas 77 percent had received at least one explicit request for a particular time. When asked if they had ever performed euthanasia or assisted in suicide, 53 percent confirmed that they had done so at some time, and 29 percent confirmed that they had done so in the preceding 24 months (Table 2). There were large differences among the three types of physicians. Among those who said they had never performed euthanasia or assisted in suicide, 35 percent said they could conceive of situations in which they would be prepared to do so. Among the remaining 12 percent, who could not conceive of such a situation, the majority said that they would be prepared to refer patients to a colleague if they requested euthanasia or assistance in suicide. These proportions are almost identical to those in the 1990 study.

Table 3 contains data obtained in the death-certificate study on the age, sex, and cause of death of the deceased persons and the type of physician involved. The percentage of all deaths in each category in which an end-of-life decision was made is shown. For instance, such a decision was made in 32 percent of all deaths of persons under the age of 50. These percentages do not differ greatly according to age or sex, but they do differ according to the cause of death: in 61 percent of all deaths from cancer, medical decisions about ending the patient's life were made, as compared with 20 percent of all deaths from cardiovascular disease. Patients who received euthanasia or assistance in suicide tended to be young. Euthanasia was more common among female patients than among male patients, a finding not consistent with the findings in the interview study and the 1990 study. This was one of the rare instances in which the results of the interview study and those of the death-certificate study differed. Euthanasia and assisted suicide predominantly involved patients with cancer (79 percent). In most cases a general practitioner was involved. (In the Netherlands, somewhat over 40 percent of all deaths occur at home.)

Ending Life without the Explicit Request of the Patient

Among the physicians interviewed, 23 percent said that at some time they had ended a patient's life without his or her explicit request, and 32 percent said that they had never done so but that they could conceive of a situation in which they would, whereas 45 percent said that they had never done so and could not conceive of any situation in which they would. The corresponding figures in the 1990 study were 27 percent, 32 percent, and 41 percent, respectively.

The patients whose lives were ended without their explicit request also tended to be relatively young, and cancer was the predominant diagnosis (in the interview study, 60 percent of all cases involved cancer). In 57 percent of all cases, clinical specialists were involved. Table 4 shows some of the characteristics of the decisions made in these cases in the death-certificate study, the drugs administered, and the estimated interval by which the patient's life was shortened. In about half of all the cases, either the decision was discussed with the patient earlier in the illness or the patient had expressed a wish for euthanasia if suffering became unbearable. In the other cases the patient was incompetent. In 95 percent of

TABLE 2. PHYSICIANS' STATEMENTS IN THE 1995 INTERVIEW STUDY ABOUT THEIR PRACTICES AND ATTITUDES WITH REGARD TO EUTHANASIA AND ASSISTED SUICIDE.*

STATED PRACTICE OR ATTITUDE	GENERAL PRACTITIONERS (N=124)	CLINICAL SPECIALISTS (N=207)	NURSING HOME PHYSICIANS (N=74)	ALL PHYSICIANS	
				1995 (N=405)	1990 (N=405)
			percent		
Performed euthanasia or assisted suicide					
Ever	63	37	21	53	54
During the previous 24 mo	38	16	3	29	24
Never performed it but would be willing to do so under certain conditions	28	43	64	35	34
Would never perform it but would refer patient seeking it to another physician	7	15	10	9	8
Would never perform it or refer patient	2	4	5	3	4

*Totals in each row cannot be computed directly as the weighted averages of separate entries, because the percentages shown are based on weighted data.

cases, the decision was discussed with colleagues, nursing staff, or relatives (or usually some combination of the three). In 64 percent of all cases in which life had been ended without the patient's explicit request, morphine was the only drug administered, whereas in 18 percent neuromuscular relaxants were used in various combinations. In 33 percent of cases life was shortened by 24 hours at most, and in a further 58 percent it was shortened by at most one week. In the interview study the proportions were similar to those in the death-certificate study.

Further scrutiny of the case histories in the interview study showed that decisions to end life without the patient's request covered a wide range of situations, with a large group of patients having only a few hours or days to live, whereas a small number had a longer life expectancy but were evidently suffering greatly, with verbal contact no longer possible. The characteristics in Table 4 suggest that most of the cases in which life was ended without the patient's explicit request were more similar to cases involving the use of large doses of opioids than to cases of euthanasia. As compared with 1990, there was a small decrease in the proportion of these cases.

Alleviation of Pain and Other Symptoms with Possible Life-Shortening Effects

Eighty-four percent of all respondents had at some time sought to alleviate a patient's pain and other symptoms by administering opioids in such doses that the patient's life might have been shortened (in 1990, 82 percent reported doing so). In 85 percent of all such cases in the death-certificate study, the physician said that he or she had no intention of hastening death, but had taken into account the probability or certainty that death would occur, whereas in the other 15 percent of cases the physician at least partly intended to hasten the patient's death. The age and sex distribution of the patients in these cases was similar to that of all persons dying in the Netherlands, but more than half the cases involved cancer. Decisions of this type are relatively frequent in nursing homes, where about 16 percent of all deaths in the Netherlands occur. In 64 percent of cases the physician estimated that the patient's life had been shortened by less than 24 hours, and in 16 percent it was shortened by less than one week (Table 4). In 43 percent of cases the decision to administer large doses of opioids was discussed with the patient and either an explicit request was made or, if the patient was incompetent, there was knowledge of a previous wish. In 86 percent of cases in which opioids were administered and there was no information about the patient's wishes, the patient was incompetent.

Decision to Forgo Treatment

Among the decisions to withhold or withdraw life-prolonging treatment, 66 percent were made with the intention of hastening death (or rather, of not prolonging life); in making the remaining decisions, the physician took into account the probability or the certainty that death would be hastened. In 10 percent of cases the decision involved artificial respiration; in 23 percent, tube feeding or artificial hydration; and in 2 percent, dialysis. The forgoing

TABLE 3. DEMOGRAPHIC AND MORTALITY VARIABLES AND DATA ON THE RESPONDING PHYSICIAN'S TYPE OF PRACTICE, ACCORDING TO THE USE OF END-OF-LIFE MEDICAL DECISIONS, IN THE DEATH-CERTIFICATE STUDY.

VARIABLE	DEATHS STUDIED		END-OF-LIFE DECISIONS IN 1995					ALL END-OF-LIFE DECISIONS		ALL DEATHS IN THE NETHERLANDS, 1995*
	NO.	PERCENT FOLLOWING END-OF-LIFE DECISION†	EUTHANASIA (N=257)	ASSISTED SUICIDE (N=25)	ENDING OF LIFE WITHOUT EXPLICIT REQUEST (N=64)	ALLEVIATION OF PAIN WITH OPIOIDS IN LARGE DOSES (N=1161)	DECISION TO FORGO TREATMENT (N=1097)	1995 (N=2604)	1990 (N=2361)	(N=135,675)
						percent‡				
Patient's age (yr)										
0–49	661	32	9	17	18	7	4	6	7	8
50–64	652	45	28	21	16	16	10	14	14	12
65–79	1792	40	43	27	31	38	31	34	36	36
≥80	2041	46	19	35	36	40	55	46	43	44
Patient's sex										
Male	2611	39	43	61	49	50	42	46	48	50
Female	2535	47	57	39	51	50	58	54	52	50
Cause of death										
Cancer	2119	61	80	78	40	54	24	41	44	27
Cardiovascular disease	910	20	3	0	5	12	16	13	16	29
Disease of nervous system	466	50	4	6	22	7	18	13	13	11
Other	1651	44	13	16	33	26	42	33	27	33
Type of physician										
General practitioner	2493	34	70	97	30	41	23	34	35	—
Clinical specialist	1560	45	27	0	57	31	42	37	40	—
Nursing home physician	929	64	2	3	14	26	32	27	24	—
Other or unknown	164	26	0	0	0	2	3	2	0	—

*Provisional figures for 1995 are shown.

†Percentages shown in this column are percentages of the number of cases studied.

‡Percentages shown in these columns are percentages of the group. Because of rounding, percentages for each variable do not all total 100.

of other treatments (such as medication, surgery, or admission to the hospital for diagnostic purposes) generally affected survival less directly. The amount of time by which life was shortened was less than 24 hours in 42 percent of cases, less than one week in 28 percent, and over one month in 8 percent. Decisions to forgo treatment differed from the other practices studied. The patients tended to be older and were more often female, and the distribution of the diseases involved more or less followed the pattern of the causes of all deaths in the Netherlands (Table 3). Decisions to forgo treatment were made relatively often by nursing home physicians.

DISCUSSION

We believe this study presents a reliable overview of medical decisions about the end of life in the Netherlands, one that includes developments since 1990. In almost all relevant respects, the interviews and the mailed questionnaires yielded similar results. Participation rates were high. Only 11 percent of physicians declined to be interviewed, mainly for lack of time, and in the death-certificate study the response rate was 77 percent. All physicians in the Netherlands received a letter signed by the president of the Royal Dutch Medical Association and the Chief Inspector for Health Care, explaining the importance of the study and urging them to cooperate if they were invited to participate. The data collected could not be used in legal prosecution.

In the reports of the 1990 study, we foresaw an increased incidence of euthanasia and the other practices examined, for several reasons — increased mortality rates as a consequence of the aging of the population, an increase in the proportion of deaths from cancer as a consequence of a decrease in deaths from ischemic heart disease, the increasing availability of life-prolonging techniques, and possibly, generational and cultural changes in patients' attitudes. At the same time, we thought it likely that the incidence of decisions to end life without an explicit request by the patient would decrease, because of the growing openness with which end-of-life decisions are discussed with patients.[1,2,6]

A coherent picture emerges from the present study that confirms these expectations. Between 1990 and 1995 there were 37 percent more requests for physician-assisted death at a later time in the course of a patient's disease and 9 percent more explicit requests at a particular time, whereas the total number

TABLE 4. CHARACTERISTICS OF VARIOUS TYPES OF MEDICAL DECISIONS RELATED TO THE END OF LIFE IN THE DEATH-CERTIFICATE STUDY.

CHARACTERISTIC	EUTHANASIA AND ASSISTED SUICIDE (N=282)	ENDING OF LIFE WITHOUT EXPLICIT REQUEST (N=64)	ALLEVIATION OF PAIN WITH OPIOIDS IN LARGE DOSES (N=1161)	DECISION TO FORGO TREATMENT (N=1097)	ENDING OF LIFE WITHOUT EXPLICIT REQUEST, 1990 STUDY (N=45)
			percent		
Previous discussion of the practice					
Discussed, explicit request made by patient	100	—	19	20	—
No explicit request, but discussed or wish stated	—	52	24	25	60
Not discussed, no previous wish	—	48	42	51	40
Unknown	—	—	15	5	—
Competence					
Yes	97	21	37	26	37
No	3	79	47	67	54
Unknown	0	0	17	7	9
Decision discussed with others*					
Colleagues	83	59	31	52	69
Nursing staff	33	65	30	47	64
Relatives or others	70	70	50	68	84
No one	4	5	16	5	2
Unknown	2	0	19	7	2
Drugs administered					
Morphine only	25	64	73	—	44†
Morphine and other drugs (but not neuromuscular relaxants)	14	17	11	—	18†
Neuromuscular relaxants (any combination)	46	18	0	—	19†
Other	12	0	2	—	19†
Unknown	2	0	15	—	0†
Amount of time by which life was shortened					
<24 hr	17	33	64	42	39
1 day to 1 wk	42	58	16	28	46
>1 wk to 1 mo	32	3	3	15	6
>1 mo	9	6	1	8	8
Unknown	0	0	15	7	0

*More than one answer is possible.

†Data are from the 1990 interview study; these questions were not asked in the 1990 death-certificate study.

of deaths increased by somewhat over 5 percent. The incidence of euthanasia increased from 1.7 percent to 2.4 percent in the death-certificate study, and from 1.9 percent to 2.3 percent in the interview study. Although variability due to sampling cannot be ruled out as an explanation, the fact that in both substudies almost identical increases were found makes an artifact very unlikely. It may be surprising that the rate of physician-assisted suicide remained constant and low, given the general tendency toward patient autonomy. It must be kept in mind, however, that in the Netherlands the physician's responsibility in physician-assisted suicide is considered to be no different from that in euthanasia.

The frequency of cases in which life was ended without an explicit request by the patient has decreased somewhat since 1990. Here too, chance fluctuation cannot be ruled out as an explanation, but the decrease was found in both studies (the 1990 interview study did not permit sufficiently reliable estimates of this variable, but the number of cases then was certainly higher than in the 1995 study). The proportion of deaths in which opioids were administered with possible life-shortening effects remained constant from 1990 to 1995, and the proportion in which life-prolonging treatment was withheld or withdrawn increased somewhat. However, there was a shift in intentions. The proportion of cases in which opioids were administered partly to hasten death dropped from 20 percent to 15 percent. It is very likely that a number of cases counted in this category in 1990 would now be considered cases of euthanasia. In the cases in which life-prolonging treatment was forgone there was also a shift toward a more explicit intention to hasten death.

Data from other countries on physicians' opinions about euthanasia and physician-assisted suicide and their actual use of these procedures are scarce. In a sample of U.S. oncologists, Emanuel et al. found that 57 percent had received a request for euthanasia or assisted death at some time, and that 14 percent had actually engaged in those practices.[7] In a sample of general practitioners and hospital consultants in the United Kingdom studied by Ward and Tate, these proportions were 45 percent and 14 percent, respectively.[8] Among physicians in South Australia

ENDING OF IFE WITHOUT LICIT REQUEST, 1990 STUDY (N=45)

60
40

37
54
9

69
64
84
2
2

44†
18†

19†
19†
0†

39
46
6
8
0

studied by Stevens and Hassan, the proportions were 33 percent and 19 percent,[9] and among Danish physicians studied by Folker et al. they were 30 percent and 5 percent.[10] Lee et al. found that 21 percent of Oregon physicians had received a request for physician-assisted suicide in the past year and that 7 percent had written at least one lethal prescription at a patient's request.[11] In Washington State 12 percent of physicians had received requests for physician-assisted suicide and 4 percent had received a request for euthanasia during the preceding year.[12] In both cases 24 percent of requests were granted. Although the comparability of the studies is limited, these figures are consistently lower than those we found.

Safe Ground or Slippery Slope?

A major issue in the debate about euthanasia is whether some form of acceptance of euthanasia or assisted suicide when it is explicitly requested by a greatly suffering, terminally ill, competent patient is the first step on a slippery slope that will lead to an unintended and undesirable increase in the number of cases of less careful end-of-life decision making and to the gradual social acceptance of euthanasia performed for morally unacceptable reasons. Obviously, our data provide no conclusive evidence in either direction. Five years may be too short a period in which to observe important cultural changes, and our results may be valid only in the context of Dutch culture and the Dutch health care system, in which virtually all of the population is insured for health care costs and economic motives have not yet entered the realm of end-of-life decision making. Nevertheless, in our view, these data do not support the idea that physicians in the Netherlands are moving down a slippery slope.

As in 1990, a large majority of Dutch physicians consider euthanasia an exceptional but accepted part of medical practice.[13] The number of requests for it has increased, but most of the requests are not granted. Physician-assisted death nowadays does not involve patients whose illnesses are less severe, as can be seen from our estimates of the amount of time by which life was shortened. Finally, there are no signs that the decision making has become less careful. Indeed, the increased frequency of consultation and better documentation of cases can be considered to indicate better decision making.[4,14] The large majority of Dutch physicians are prepared to invest substantial time in participating in studies of this type and to make information on this difficult area of their practices public. As a result, further developments in end-of-life decision making can be monitored closely.

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We are indebted to Johannes J.M. van Delden, M.D., Ph.D., Johanna H. Groenewoud, M.D., and Piet J. Kostense, Ph.D., for their contributions to the study and to the manuscript; to Magda M. Henke-Kulakowska, M.D., Martien T. Muller, Ph.D., Henk Noort, M.A., and Marjolein D. Smit, M.D., for their contributions to the study; to Loes Pijnenborg, M.D., Ph.D., for her contribution to the manuscript; to the members of the Steering Committee for their continuous support throughout the study; to the thousands of physicians and public prosecutors who provided the study data; to the interviewers; and to the Royal Dutch Medical Association and the Chief Inspector for Health Care for their support of the study.

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Exhibit 2

Montana
Department of Labor and Industry
Business Standards Division
Governor Brian Schweitzer

STATEMENT ON THE USE OF CONTROLLED SUBSTANCES IN THE TREATMENT OF INTRACTABLE PAIN

The Montana Board of Medical Examiners continues to be concerned about the use of controlled substances by individuals who seek them for their mood-altering and addictive potential rather than legitimate medical reasons. However, the Board is also concerned about adequate pain management. The Board recognizes that pain from whatever cause is often under-treated. The Board is aware that there are a number of factors that continue to interfere with effective pain management. These include exaggerated fears of opioid side effects including addiction, fear of legal consequences when controlled substances are used, low priority of proper pain management in our health care system, and the lack of integration of current knowledge concerning pain management into medical education and clinical practice.

The Board seeks to assure that no Montanan requiring narcotics for pain relief is denied them because of a physician's real or perceived fear that the Board of Medical Examiners will take disciplinary action based solely on the use of narcotics to relieve pain. While improper use of narcotics, like any improper medical care, will continue to be a concern of the Board, the Board is aware that treatment of malignant and especially nonmalignant pain is a very difficult task. The Board does not want to be a hindrance to the proper use of opioid analgesics. Treatment of chronic pain is multifactorial and certainly treatment with modalities other than opioid analgesics should be utilized, usually before long term opioids are prescribed. Use of new or alternative types of treatment should always be considered for intractable pain periodically, in attempts to either cease opioid medications or reduce their use.

The proper use of opioid analgesics for chronic pain must involve certain elements, which are also consistent with any quality medical care. The following guidelines will help assure the proper use of these medications for chronic pain and minimize the improper use:

GUIDELINES FOR PRESCRIBING OPIOID ANALGESICS FOR CHRONIC PAIN

1. **Thorough history and physical examination**. Included in the history is assessment of the etiology of pain, physical and psychological function of the patient, substance abuse history, other treatments that have been attempted to control the patient's level of pain, identification of underlying or co-existing diseases or conditions and, as much as possible, statements by all treating physicians that the patient's pain is intractable and not controlled by other than the use of opioid analgesics.

2. **Treatment plan**. A thoroughly documented, written treatment plan should be established and should include how treatment success will be evaluated, such as pain relief and improved physical or psychological functioning. Several treatment modalities should be utilized in most cases and should be done concurrently with the use of opiates. Periodic review by the physician should be accomplished to determine that there are no other appropriate treatment methods that would then be of additional benefit to the patient.

Exhibit 3

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MONTANA FIRST JUDICIAL DISTRICT COURT,
LEWIS AND CLARK COUNTY

ROBERT BAXTER, STEVEN STOELB, STEPHEN SPECKART, M.D., C. PAUL LOEHNEN, M.D., LAR AUTIO, M.D., GEORGE RISI, JR., M.D. and COMPASSION & CHOICES,

Plaintiffs,

v.

STATE OF MONTANA and MIKE MCGRATH, ATTORNEY GENERAL,

Defendants.

Judge: Dorothy McCarter
Cause No. ADV 2007-787

PLAINTIFFS' RESPONSES TO STATE OF MONTANA'S FIRST DISCOVERY REQUESTS

Plaintiffs respond to Defendant State of Montana's First Discovery Requests as follows:

INTERROGATORY NO. 1: Define "aid in dying" as it is used in the Complaint, including the specific medication(s) and process(es) involved, any differences between the type, dose, and amount of medication prescribed for palliative care and "aid in dying," the resulting

physiological effects, the physician's specific role, and any other objective standards that delimit the definition.

ANSWER: The term "aid in dying", as used in plaintiffs' complaint, refers to the right of a mentally competent, terminally ill adult patient to obtain a prescription for a lethal dose of medication from a cooperating physician, which the patient may elect to self-administer to bring about a peaceful death. It also includes the right of a patient to obtain medical information from the physician for the same purpose. It is up to the doctor to determine the type and dose of medication to be used. As aid in dying is practiced in Oregon, in most cases an oral dose of a barbiturate is chosen. The medication acts to induce unconsciousness and depress respiratory and cardiac function, thereby causing death. Palliative care can involve either the same or different categories of medications than aid in dying, depending on the attending doctor's choice, but typically involves small doses of a sedative administered over time.

INTERROGATORY NO. 2: Define "physician" as it is used in the Complaint, including the medical and legal qualifications of a person who would provide aid in dying, the length of time treating the patient, and any other objective standards that delimit the definition.

ANSWER: The term "physician", as used in the complaint, means a person who holds a degree as a doctor of medicine or doctor of osteopathy and who has a valid license to practice medicine or osteopathic medicine in Montana. See 37-3-102(7), MCA.

INTERROGATORY NO. 3: Define "mentally competent" as it is used in the Complaint, including the specific standard of mental competency, how it will be assessed, who will assess it, and any other objective standards that delimit the definition.

ANSWER: The term "mentally competent", as used in the complaint, means that the

person understands what he or she is doing and the probable consequences of his or her acts. Mental competence will be determined by the person's attending physician based upon the physician's professional judgment and assessment of the relevant medical evidence.

INTERROGATORY NO. 4: Define "terminally ill adult patient" as it is used in the Complaint, including the specific class that Plaintiff Patients' purport to represent, the diseases that may qualify for terminal illness, expected terminal prognosis, who will determine the diagnosis and prognosis, and any other objective standards that delimit the definition.

ANSWER: The term "terminally ill adult patient", as used in the complaint, means a person 18 years of age or older who has an incurable or irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of his or her attending physician, result in death within a relatively short time. This definition is not limited to any specific set of illnesses, conditions or diseases. The patient plaintiffs in this case represent the class of Montana citizens who are mentally competent, adult, terminally ill under this definition, and wish to avail themselves of the right to aid in dying. The patient's diagnosis and prognosis will be determined by his or her attending physician.

INTERROGATORY NO. 5: Define "a dying process the patient finds intolerable" as it is used in the Complaint, including any objective standards that delimit the definition.

ANSWER: This is a subjective determination made by the individual patient based upon his or her medical condition and circumstances, symptoms, and personal values and beliefs.

INTERROGATORY NO. 6: Define how a patient seeking "aid in dying" "requests such assistance" as it is described in the Complaint.

ANSWER: A patient seeking aid in dying typically makes his or her wishes known, and asks the attending physician for assistance of this kind, during the course of the doctor - patient relationship. The request can be made in oral, written, or both forms. As the practice exists in Oregon, requests are made in both oral and written formats.

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INTERROGATORY NO. 7: Specify the approximate proportion of persons in Montana that will qualify as "terminally ill adult patients" at some time in their lives. If you are unable to do so, specify the current number of patients treated by each physician that will qualify as "terminally ill adult patients at some time in their lives.

ANSWER: Unknown. Plaintiffs do not know the percentage of Montanans who: a) while they are adults as opposed to minors; b) will become patients during the course of dying, as opposed to those who die without coming under the care of doctors; and c) will develop an incurable or irreversible condition that results in death over a period of time, as opposed to dying suddenly. In general, however, all Montanans, unless they do die suddenly, are likely to become "terminally ill", and the great majority of these are likely to become patients of physicians.

INTERROGATORY NO. 8: Specify the approximate current number of patients in Montana that qualify as "terminally ill adult patients." If you are unable to do so, specify the current number of patients treated by each physician that qualify as "terminally ill adult patients."

ANSWER: Unknown. See answer to Interrogatory No. 7. All of the physician plaintiffs have treated numerous individuals who qualify as "terminally ill adult patients", the number of which varies at any point in time.

INTERROGATORY NO. 9: Specify the approximate current number of patients in Montana that qualify as "terminally ill adult patients" but are incapable of receiving "aid in

dying" for reasons unrelated to mental competency.

ANSWER: Unknown.

INTERROGATORY NO. 10: Describe any diagnosis of or therapy for each Plaintiff Patient concerning depression or any other mental health condition that occurred during his terminal illness or otherwise relates to their mental competency to request and receive "aid in dying," and identify the individual who provided the diagnosis or therapy.

ANSWER:

1. Robert Baxter: none

2. Steven Stoelb: Mr. Stoelb has been diagnosed with depression, situational depression, and stress related to his disease on various occasions during the course of his illness. The diagnoses were given by Dr. Mark Schulein and other representatives of Community Health Partners in Livingston, Montana. Treatment has included brief trials of anti-depressants, which were not useful and were discontinued, and general counseling by these same providers and Hospice employees.

INTERROGATORY NO. 11: Describe all efforts you have taken, or are aware of, to change Montana law to allow "aid in dying" through the legislative, initiative, or other political processes.

ANSWER: Plaintiffs have not undertaken any such efforts, and are unaware of anyone else who may have done so.

INTERROGATORY NO. 12: Describe all known efforts to charge, threaten to charge, investigate, or otherwise seek to enforce Mont. Code Ann. §§45-5-102, -103, or -104 against

physicians in Montana who provide "aid in dying" to mentally competent, terminally ill patients who request such assistance.

ANSWER: Unknown; this information is within the possession of law enforcement officials.

INTERROGATORY NO. 13: Describe all known efforts to charge, threaten to charge, investigate or otherwise seek to enforce Mont. Code Ann. §§45-5-102, -103, or -104 against physicians in Montana who provide palliative care without the intent to cause death, including terminal sedation, to mentally competent, terminally ill patients who request such care.

ANSWER: Unknown; this information is within the possession of law enforcement officials.

INTERROGATORY NO. 14: Describe all known efforts to charge, threaten to charge, investigate, or otherwise seek to enforce Mont. Code Ann. §§45-5-105.

ANSWER: Unknown; this information is within the possession of law enforcement officials.

INTERROGATORY NO. 15: Explain, in detail, how the specific elements of Mont. Code Ann. §§45-5-102, -103, and -104 apply to the acts of a physician who provides aid in dying to a mentally competent, terminally ill adult patient facing a dying process the patient finds intolerable.

ANSWER: As indicated in their complaint, it is plaintiffs' belief and contention that the criminal homicide statutes may not be applied to a physician under such circumstances, as to do so would violate rights guaranteed to plaintiffs, as well as other terminally ill patients treated by

the plaintiff physicians, by Article II, Sections 3, 4, 10 and 17 of the Montana Constitution. Complaint, ¶¶ 26, 27.

Plaintiffs also believe and contend that the Montana statutes relating to criminal homicide do not reach the conduct of a physician who provides aid in dying for his or her patient. The provisions that define criminal offenses in the state reflect an intent to safeguard conduct that is without fault from criminal prosecution; to give fair warning of the nature of the acts that *are* declared to constitute an offense; and to promote justice. Section 45-1-102, MCA. The language and fair import of the homicide statutes indicate they should not apply to a physician who, at the express request of a patient seeking to hasten impending death in order to minimize suffering and end life in a peaceful and dignified manner, does nothing more than provide a prescription that the patient is then free to do with as he or she chooses.

Plaintiffs' contentions notwithstanding, however, this case is centered around the fact that the existence of the homicide statutes, and the serious personal threat they represent depending upon how they are interpreted and applied, deter physicians from acting as their patients and they both believe they should. The result is the denial of the patients' and doctors' legal rights as described above.

Taking the statutes at face value, a person who purposely or knowingly causes the death of another human being commits the offense of Deliberate Homicide. Section 45-2-102, MCA. A person who purposely or knowingly causes the death of another human being while under the influence of extreme mental or emotional stress for which there is reasonable explanation or excuse commits the offense of Mitigated Deliberate Homicide. Section 45-2-103, MCA. A person who negligently causes the death of another human being commits the offense of Negligent Homicide. Section 45-2-104, MCA. For purposes of the criminal homicide statutes, conduct is deemed the cause of another's death if without the conduct the death would not have

occurred. Section 45-2-201, MCA. Given that definition, a physician who provides aid in dying to a terminally ill patient who dies as a result, under circumstances in which the patient would not have died at that time without such assistance, may be prosecuted for homicide.

The consent of the victim to a defendant's conduct or its result is a defense to a criminal charge in Montana. Section 45-2-211(1), MCA. Consent is deemed ineffective, however, if it is against public policy to permit the conduct or the resulting harm, even though consented to. Section 45-2-211(2)(d), MCA. Plaintiffs contend in their complaint that it is, or in light of the rights guaranteed by the Montana Constitution should be declared to be, the public policy of the State of Montana to allow physicians to provide aid in dying to their mentally competent, terminally ill adult patients who are experiencing severe suffering at the end of life and request such assistance. Complaint, ¶23. Defendants have denied this claim. Answer, ¶23. If the court rules against plaintiffs and in favor of the State on the public policy issue, then the patient's consent to the aid in dying provided by the physician will be deemed ineffective, and the consent defense itself will be rejected. The result will be to leave the physician exposed to a conviction for criminal homicide, notwithstanding the fact that the patient – the nominal "victim" – sought and expressly agreed to the doctor's conduct.

INTERROGATORY NO. 16: Identify each person who may testify for you as a witness or affiant in this matter, whether layperson or expert, and summarize the subject of their testimony.

ANSWER: No decisions have yet been made as to who may be asked to testify for the plaintiffs, either live or through affidavit, or what their testimony will involve. It is likely, however, that one or more of the named plaintiffs will be asked to testify about the factual matters described in the complaint that relate to them.

REQUEST FOR PRODUCTION NO. 1: Produce any documents you rely upon for your responses to these interrogatories.

RESPONSE: Plaintiffs object to this request on the ground that the information it seeks is protected against disclosure by the attorney work-product and attorney mental-impression privileges.

REQUEST FOR PRODUCTION NO. 2: Produce each document you may use as a summary judgment or trial exhibit in this matter.

RESPONSE: No decisions have yet been made as to what documents or other evidence plaintiffs may use at trial or in support of a motion for summary judgment.

REQUEST FOR ADMISSION NO. 1: Palliative care is treatment for the dying that focuses on relieving pain and discomfort rather than on fighting disease.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 2: Terminal sedation is a form of palliative care that uses high doses of sedatives to render the patient unconscious to relieve otherwise intolerable suffering.

RESPONSE: Admit, with clarification that with terminal sedation, also referred to as palliative sedation, artificial food and fluid is withheld from the sedated patient.

REQUEST FOR ADMISSION NO. 3: The "double effect" doctrine describes an action that has two effects, one that is intended and positive and one that is foreseen but negative, but is ethically acceptable if the actor intends only the positive effect.

RESPONSE: The doctrine of double effect is described in treatises and literature in a number of different ways, and plaintiffs are unaware of this particular definition. The request is therefore denied.

REQUEST FOR ADMISSION NO. 4: The "double effect" doctrine applies to treatments by high doses of pain medication or terminal sedation that are intended to relieve suffering but that also will hasten death.

RESPONSE: See response to Request for Admission No. 3. Plaintiffs admit that the double effect doctrine may apply under such circumstances under some definitions of the doctrine.

REQUEST FOR ADMISSION NO. 5: Palliative care, including terminal sedation, is not homicide under Montana law when the physician's intent is to relieve suffering and not to cause the death of the patient.

RESPONSE: Deny. Montana law is not settled on this issue. See also answer to Interrogatory No. 15.

REQUEST FOR ADMISSION NO. 6: For "aid in dying" to constitute a criminal offense under Mont. Code Ann. §§45-5-102, -103, or -104, a physician must voluntarily cause the death of the patient.

RESPONSE: Deny as framed. Plaintiffs admit that, pursuant to Section 45-2-202, MCA, a material element of each offense is a voluntary act. See also answer to Interrogatory No. 15.

REQUEST FOR ADMISSION NO. 7: For "aid in dying" to constitute a criminal

offense under Mont. Code Ann. §§45-5-102, a physician must either: 1) have the conscious object to cause the patient's death, unless that purpose is conditional and the condition negatives the harm or evil sought to be prevented by the statute; or 2) be aware that it is highly probable that he will cause the patient's death.

RESPONSE: Deny as framed. Plaintiffs admit that the definitions of "purposely" and "knowingly", as set forth in Sections 45-2-101(65) and (35), MCA, are among the elements of the offense. See also answer to Interrogatory No. 15.

REQUEST FOR ADMISSION NO. 8: In providing "aid in dying," if Plaintiff Physicians have the conscious object to cause the patient's death, that purpose would be conditional on providing palliative care through means other than solely hastening death.

RESPONSE: Deny. This request is not comprehensible, and plaintiffs are unable to understand what "palliative care through means other than solely hastening death" means or how it would apply. See also answer to Interrogatory No. 15.

REQUEST FOR ADMISSION NO. 9: For "aid in dying" to constitute a criminal offense under Mont. Code Ann. §§45-5-103, a physician must cause the patient's death under the influence of extreme mental or emotional stress for which there is reasonable explanation or excuse.

RESPONSE: Admit, with the clarification that the statute also requires the physician to act purposely or knowingly. See also answer to Interrogatory No. 15.

REQUEST FOR ADMISSION NO. 10: In providing "aid in dying," Plaintiff Physicians would not act under the influence of extreme mental or emotional stress for which

there is reasonable explanation or excuse.

RESPONSE: The type, degree, and explanation or excuse for the stress experienced by a physician under such circumstances, and how the stress would likely be characterized by a prosecutor, jury, trial judge or appellate court, could vary substantially from case to case; and a categorical statement to this effect accordingly cannot be made. The request is therefore denied. See also answer to Interrogatory No. 15.

REQUEST FOR ADMISSION NO. 11: For "aid in dying" to constitute a criminal offense under Mont. Code Ann. §§45-5-104, a physician must consciously disregard the risk, or disregard the risk of which the physician should be aware, in a gross deviation from the standard of conduct that a reasonable person would observe in the actor's situation, that providing "aid in dying" will cause the patient's death.

RESPONSE: Deny as framed. Plaintiffs admit that the definition of "negligently", as set forth in Section 45-2-101(43), MCA, is among the elements of the offense. See also answer to Interrogatory No. 15.

REQUEST FOR ADMISSION NO. 12: In providing "aid in dying," Plaintiff Physicians would not grossly deviate from the standard of conduct that a reasonable person would observe in the physician's situation.

RESPONSE: The standard of conduct that a reasonable person would observe in the physician's situation, and how it would likely be characterized by a prosecutor, jury, trial judge or appellate court, could vary substantially from case to case; and a categorical statement to this effect accordingly cannot be made. The request is therefore denied. See also answer to Interrogatory No. 15.

REQUEST FOR ADMISSION NO. 13: The American Medical Association ("AMA") is the largest association of physicians in the United States.

RESPONSE: Plaintiffs admit that the American Medical Association claims to be "the nation's largest physician group", but have no reasonable way of verifying or disproving this claim. Plaintiffs therefore deny the request due to lack of information or knowledge.

REQUEST FOR ADMISSION NO. 14: The AMA publishes the Journal of the American Medical Association, which has the largest circulation of any weekly medical journal in the world.

RESPONSE: Admit that the AMA publishes the Journal of the American Medical Association. Plaintiffs acknowledge that Wikipedia, an online encyclopedia, describes JAMA as having "the largest circulation of any weekly medical journal in the world", but have no reasonable way of verifying or disproving this claim and accordingly deny this portion of the request due to lack of information or knowledge.

REQUEST FOR ADMISSION NO. 15: The AMA's Council on Ethical and Judicial Affairs, upon deliberation and approval by the AMA's House of Delegates, prepares the AMA's *Code of Medical Ethics*.

RESPONSE: Deny as framed. Plaintiffs admit that the Council on Ethical and Judicial Affairs prepares reports on ethical issues which are then considered by the AMA's House of Delegates. If approved by the House of Delegates, the recommendations become the official policy of the Association and ultimately serve as the basis for updating the AMA's *Code of Medical Ethics*.

REQUEST FOR ADMISSION NO. 16: Opinion E-2.20 of the *Code of Medical Ethics* (available at www.ama-assn.org) provides in part, "Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death."

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 17: Opinion E-2.21 of the *Code of Medical Ethics* (available at www.ama-assn.org) defines Euthanasia as "the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering." That opinion provides in part, "[P]ermitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations. Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life."

RESPONSE: Admit, but affirmatively state that Opinion E-2.21 also includes the following additional statements: "It is understandable, though tragic, that some patients in extreme duress – such as those suffering from a terminal, painful, debilitating illness – may come to decide that death is preferable to life....Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication."

REQUEST FOR ADMISSION NO. 18: Opinion E-2.22 of the *Code of Medical Ethics* (available at www.ama-assn.org) defines Physician-Assisted Suicide as "when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide)." That opinion provides in part, "[A]llowing physicians to participate in assisted suicide would cause more harm than good. Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks. Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life."

RESPONSE: Deny as framed. The quoted language does appear, however, in Opinion E-2.211. Plaintiffs affirmatively state that Opinion E-2.211 also includes the following additional statements: "It is understandable, though tragic, that some patients in extreme duress – such as those suffering from a terminal, painful, debilitating illness – may come to decide that death is preferable to life....Patients should not be abandoned once it is determined that cure is impossible....Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication."

Plaintiffs also note that application of the term "physician-assisted suicide" to the practice of prescribing medication for a mentally competent, terminally ill patient which the patient can then self-administer for the purpose of bringing about a peaceful death has been rejected by a number of medical and health policy organizations including the American Medical Women's Association, the American Medical Students' Association, the American Academy of Hospice and Palliative Medicine, and the American Public Health Association.

REQUEST FOR ADMISSION NO. 19: The class of "terminally ill adult patients" includes individuals of every race, color, sex, age, culture, social origin and condition, and political and religious ideas.

RESPONSE: Deny as framed, as by definition the class of "terminally ill adult patients" includes only people who are 18 years of age or older. With this qualification, plaintiffs admit the remainder of the request.

REQUEST FOR ADMISSION NO. 20: A majority of individuals either qualify as a "terminally ill adult patients" [sic] at some time in their lives, or has a close friend or family member or [sic] will so qualify.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 21: The Plaintiff Physicians are not board-certified in psychiatry or any of its board-certified subspecialties, including pain medicine.

RESPONSE: Admit.

REQUEST FOR ADMISSION NO. 22: The Plaintiff Physicians are not board-certified in anesthesiology or any of its board-certified subspecialties, including pain medicine.

RESPONSE: Admit.

INTERROGATORY NO. 17: For each request for admission you do not unequivocally admit, explain the basis of your failure to do so.

ANSWER: See previous discovery responses.

REQUEST FOR PRODUCTION NO. 3: For each request for admission you do not unequivocally admit, produce any document you rely upon as a basis for your failure to do so.

RESPONSE: Plaintiffs object to this request on the ground that the information it seeks is protected against disclosure by the attorney work-product and attorney mental-impression privileges.

INTERROGATORY NO. 18: Identify, by interrogatory, the individual(s) who responds to each interrogatory.

ANSWER: All interrogatory answers have been provided by plaintiffs' counsel.

DATED this 16th day of May, 2008

CONNELL LAW FIRM

By: _____
Mark S. Connell
Attorneys for Plaintiffs

CERTIFICATE OF SERVICE

I, Marie Hartig, legal assistant of the Connell Law Firm, do hereby state that on this date, I served a true and correct copy of the foregoing document upon the individual listed below, via the following means:

Jennifer Anders
Anthony Johnstone
Attorney General's Office
PO Box 201401
Helena, MT 59620-1401

[x]U.S. Mail
[ ]Facsimile
[ ]Certified Mail
[ ]Hand Delivery

Dated this 16th day of May, 2008.

Marie Hartig, Legal Assistant

Exhibit 4

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COUNSEL FOR DEFENDANTS

MONTANA FIRST JUDICIAL DISTRICT COURT
LEWIS AND CLARK COUNTY

ROBERT BAXTER, STEVEN STOELB, STEPHEN SPECKART, M.D., C. PAUL LOEHNEN, M.D., LAR AUTIO, M.D., GEORGE RISI, JR., M.D., and COMPASSION & CHOICES, Plaintiffs, v. STATE OF MONTANA and MIKE McGRATH, Defendants.	Cause No. ADV 2007-787 **AFFIDAVIT OF JOHN P. CONNOR, JR.**

STATE OF MONTANA)
: ss.
County of Lewis and Clark)

JOHN P. CONNOR, JR., being first duly sworn upon his oath, deposes and says:

1. He is Chief Criminal Counsel for the Montana Attorney General's Office.

2. In such capacity he is responsible for general supervision of the prosecution functions of the Attorney General's Office, and has held that position for approximately 20 years.

3. He also acts as special counsel for counties throughout the state, and has prosecuted major felony cases, including deliberate homicide, mitigated deliberate homicide and negligent homicide.

4. He oversees the work of six other prosecutors in the office, who collectively prosecute dozens of felony cases each year, including deliberate, mitigated and negligent homicide cases.

5. In 2004, the Attorney General's office provided prosecution assistance to Madison County in State v. Bischoff, Cause No. DC-27-04-23, which involved a case in which a medical doctor, James Bischoff, administered life-ending drugs to a patient without evidence of the patient's permission or that of the patient's family. Bischoff made several admissions to that effect, and was subsequently prosecuted for deliberate homicide. He pled guilty to negligent homicide and was committed to the Department of Corrections for ten years with five suspended.

6. The undersigned is not aware of any prosecutions completed or pending under the factual scenario set forth in Plaintiff's complaint, that is, a doctor prescribing lethal doses of pain medication to a terminally ill patient, with probable knowledge that the patient may take the medication to bring about his or her death.

7. The undersigned is not aware of any prosecutions completed or pending in Montana pursuant to Mont. Code Ann. § 45-5-105, Aiding or Soliciting Suicide.

8. The undersigned is not aware of any criminal charges brought or being prepared or contemplated against a doctor for providing medication to a terminally ill patient to relieve suffering, as part of palliative care, even if that

medication ultimately hastened death or rendered the patient unconscious. In my professional judgment based on my experience, such action by a physician caring for a patient would not constitute a criminal act because there is no specific mental state to cause death; that is, the physician would not be acting with purpose or knowledge to cause death as those terms are defined in Montana law.

9. To my knowledge there is no prohibition in Montana criminal law precluding a physician from prescribing medication, even in a potentially lethal amount, to a patient who requires such medication for pain management.

10. Further affiant sayeth not.

JOHN P. CONNOR, JR.

Subscribed and sworn to before me this 1st day of August, 2008.

BUFFY L. EKOLA NOTARIAL SEAL STATE OF MONTANA

Printed Name: Buffy L. Ekola
Residing at Helena, Montana.
My Commission expires: January 21, 2011

Exhibit 5

FILED

AUG 26 2004

By Clerk of Court
Deputy Clerk

Robert R. Zenker
Madison County Attorney
Attorney for the State of Montana
P.O. Box 73
Virginia City, MT 59755
(406) 843-4233

MONTANA FIFTH JUDICIAL DISTRICT COURT, MADISON COUNTY

THE STATE OF MONTANA, *
Plaintiff, *
-vs- *
*
JAMES STEPHEN BISCHOFF, *
Defendant. *

Cause No. DC-29-04-23

AFFIDAVIT OF PROBABLE CAUSE

* *

STATE OF MONTANA
County of Madison

ROBERT R. ZENKER, being first duly sworn, deposes and says:

1. That he is the duly appointed, qualified and acting County Attorney of Madison County and makes this Affidavit for the purpose of charging the Defendant with the crime of DELIBERATE HOMICIDE, A FELONY, in violation of Mont. Code Ann. § 45-5-102(1)(a), punishable by death as provided in Mont. Code Ann. § 46-18-301 through 46-18-310, or by life imprisonment, or by imprisonment in the state prison for a term of not less than 10 years or more than 100 years, except as provided in Mont. Code Ann. §§ 46-18-219 and 46-18-222.

2. This affidavit is based upon the investigation of Agent Reed Scott, Division of Criminal Investigation, Department of Justice of the State of Montana.

3. The facts constituting the offense is as follows:

Kathryn Dvarishkis was brought to the Madison Valley Hospital in Ennis, Montana at about 7:15 a.m. on July 11, 2000 after apparently suffering a heart attack. Mrs. Dvarishkis, eighty five (85)

years old, was found to be cyanotic, diaphoretic, was unresponsive to verbal commands and had labored respirations. Her oxygen saturation on admission was fifty three per cent (53%) and respiration rate was thirty six (36). Her diagnosis was recorded as an acute myocardial infarction (MI), complicated by post-MI congestive heart failure, hypoxia, suspected cardiovascular accident, Alzheimer's disease and diabetes.

Mrs. Dvarishkis survived at the Madison County Hospital for six (6) days. She had a living will, and the expectation of family members was that she would be given compassionate support, but little or no active medical support beyond that. Family members were with her for much of the time. During her stay, the medical records indicate that she was given compassionate support, including medication to try to keep her pain free. The nursing notes indicate that Mrs. Dvarishkis was semi-conscious or sleeping for virtually the entire period of hospitalization. She apparently spoke a few words during her first day in the hospital (July 11th 11:40 a.m. - "I feel better"), but for the most part was sleeping. She often moaned or cried out.

To make Mrs. Dvarishkis feel more comfortable, the attending physician, the Defendant, prescribed Morphine and Ativan (lorazepam). On July 11th, Morphine Sulphate 5-10 mg. i/m (Intramuscular) was prescribed "as needed" for respiratory distress or sleep. Later, Ativan was added at a dose of 2 mg. i/m for restlessness. The nursing records indicate that both of these medications were administered several times during the first few days. On July 14th, the progress notes indicate that the Defendant increased the dose of Morphine 10-20 mg. i/m "as needed", in response to the fact that Mrs. Dvarishkis was still periodically moaning and crying out.

On July 16th at 2:15 p.m, the nursing notes indicate that an intravenous line was started in response to an order given by the Defendant. The nursing notes continued to state *"Meds given per Dr. Bischoff - see Dr. Progress notes."* The nursing notes then indicate at 2:32 p.m. *"Pt. pronounced dead per Dr. Bischoff"* and at 2: 40 p.m. *"...mortuary notified."*

The purpose stated by the Defendant's progress notes for starting the intravenous line was that, essentially, i/v Morphine may be more effective [in controlling comfort] than the i/m route. In the same notation, the Defendant increased the order for Morphine to 20-40 mg. i/v or i/m. Defendant wrote about two (2) pages of notes, wherein he records the conversations he had with the

family and that administration of Fentanyl was offered by Defendant as an option. Defendant explained that Fentanyl is more potent than Morphine and may cause more respiratory depression. Defendant gave 100 mcg Fentanyl at 2:15 p.m. and five (5) mg. Versed (midazolam) at 2:16 p.m. Defendant further recorded that he gave an additional dose of 100 mcg. Fentanyl at 2:24 p.m. and an additional dose of 5 mg. Versed at 2:25 p.m. Defendant states Mrs. Dvarishkis stopped breathing at 2:32 p.m. and that he pronounced her dead at that time.

Linda Ryan, employed as a registered nurse at the Madison Valley Hospital since April of 1995, stated that Defendant requested that she place a heplock (i/v access point) in Mrs. Dvarishkis. Ryan said the Defendant then administered Fentanyl and Versed. Ryan said the Defendant failed to sign the drugs out as required. Ryan said she had to sign the drugs out to the patient. Ryan informed investigators that the drugs given to this patient "...would, if they don't have a lot of time left, it's probably going to kill them." Ryan told the Defendant "If you have the guts to do this then you better have the guts to chart it, Dr. Bischoff. You need to sign out your narcotics." Defendant said to Lynda Ryan that he felt powerful.

A forensic toxicologist Dr. Graham R. Jones, has reviewed the Dvarishkis file at the request of investigators. Dr. Jones has a Ph.D. in Pharmaceutical Chemistry, and is a Diplomat of the American Board of Forensic Toxicology. He is the Chief Toxicologist for the Province of Alberta, Canada, and a clinical instructor in the School of Pharmacy at the University of Alberta. Dr. Jones is the current Director of the American Board of Forensic Toxicology and the former Chairman of the Canadian Society of Forensic Science, Toxicology Section, along with membership in numerous professional societies. He routinely serves as Editor and Reviewer of Forensic and Toxicology journals, has been awarded numerous professional toxicology awards, and has authored nearly one hundred publications. He reports as follows:

> During the first dew days of Mrs. Dvarishkis' hospitalization, there was not anything unusual or pharmacologically unsound in the prescription of Morphine and Ativan. This elderly, and apparently terminally ill lady was clearly distressed and in discomfort. In such circumstances, the gradually escalating doses of Morphine (5-10 mg., then 10-20 mg.) combined with Ativan, is pharmacologically appropriate and consistent with accepted medical practice. The first administration of Fentanyl and Versed is unusual in that both drugs are very short-acting (particularly Versed, compared with Ativan) and is considered inappropriate where the goal is to keep a patient comfortable, rather than to treat an acute event. However, the second doses

of both Fentanyl and Versed followed so quickly after the first doses, were predictably, an imminent threat to life. In plain language, there is no other conclusion that the Fentanyl and Versed were administered to hasten death.

Sandy Dvarishkis was present when the Defendant administered fatal drugs to her mother at the Madison Valley Hospital. The Defendant had approached her father about ending her mother's life. Sandy Dvarishkis said the drugs were administered by the Defendant, who then listened to her mother's heart. The Defendant made a statement about "the woman being as strong as a horse," as her heart was still beating. Defendant left the room and returned with another dose of drugs and administered them, killing the patient. Sandy Dvarishkis said the Defendant was nervous during the procedure.

Margaret Bortko is a family nurse practitioner in private practice and also covered the emergency room at the Madison Valley Hospital. Bortko stated that the Defendant would brag about his involvement in cases of hastening death and that the Defendant felt he was doing everybody a favor.

Further affiant sayeth naught.

Dated: 24 August, 2004.

ROBERT R. ZENKER
Madison County Attorney

Subscribed and sworn to before me this 24 day of August, 2004.

Patty Davis
NOTARY PUBLIC
My commission expires 9/23/2007

PATTY DAVIS NOTARIAL SEAL STATE OF MONTANA